Duddon Valley Medical PracticeDuddon Valley Medical Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Duddon Valley serves 3,600 patients across their two surgeries at Kirkby in Furness and Foxfield Rd, Broughton in Furness. Patients register with the practice and can then choose which surgery to attend or where to pick their medicines up from. There are normally two GP's at the practice, however at the time of inspection one was off on long-term leave with no known return date, so the practice had one full-time male GP and a female locum GP 2 days a week.

The service is registered with CQC for the regulated activities of treatment of disease, disorder and injury, and diagnostic and screening services. Maternity, midwifery and family planning services are also registered, as are minor surgical procedures.

Overall, we found the service provided caring and sympathetic, patient-centred care. People were able to access the service when required. People we spoke with and the comment cards we reviewed were almost all positive, with people highlighting the good standard of care provided. The surgeries and treatment rooms were clean and tidy, and on the whole medicines were managed safely.

We found the practice had made many improvements over the last three months and many previously absent procedures had recently been implemented, such as disciplinary and grievance policies for staff. However, at the time of inspection workers were not appropriately supported in their roles through a system of supervisions and appraisals, which would identify problems and learning needs. This could have a negative impact on patient outcomes.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall we found this service was safe. There were effective systems in place to record and report allegations of abuse, and staff could describe their roles in these processes.

The practice had policies and procedures in place to ensure that the surgeries, instruments and equipment were kept clean and did not present an infection control risk. Medicines were managed safely. There were systems in place to record and investigate incidents. Staff were trained and able to respond to emergencies.

Are services effective?

We found some aspects of this service required improvement. There was a system to monitor and promote clinical best practice, and staff worked with patients to develop care plans for their complex or long term conditions. There was some evidence of health promotion and identifying those at risk of ill health.

However, staff had never had the benefit of formal supervisions or appraisals, meaning their learning needs had not been identified. This could have a negative impact on patient outcomes

Are services caring?

Overall we found this service was caring. Patients spoke highly of the GP's and staff and said the service was kind, caring and compassionate, and that they were treated with respect. We confirmed this during our observations of staff.

Are services responsive to people's needs?

Overall we found the service to be responsive. People could generally access the service when required. Sufficient numbers of appointments were available, and people could request telephone appointments or home visits. In general, people were supported with timely referrals and to receive their results.

Are services well-led?

Overall, we found the service showed some characteristics of being well-led. The practice had employed the services of a Practice Support & Training Consultant, in recognition of the fact that many policies and management procedures had been previously absent. We found that much progress had been made, and staff were engaged with this process. The practice still needed to develop clear roles and responsibilities for staff and communicate a clear vision statement for the future.

Summary of findings

What people who use the service say

We spoke with seven patients and collected 15 comments cards across both surgeries. Comments were almost universally positive about the service provided. People described the service as caring and effective, and the staff as friendly and courteous. People said they were able to book appointments without difficulty. There was some negative feedback about the lack of privacy in the small waiting rooms at each surgery, although the provider had taken some steps to try to rectify this.

Areas for improvement

Action the service MUST take to improve

The provider did not have arrangements in place to ensure that staff were appropriately supported in relation to their responsibilities, including through an appropriate system of supervisions and appraisals.

The practice must ensure that staff are regularly supported, through being given opportunity to discuss problems and identify learning needs and objectives.

Action the service COULD take to improve

The practice could engage with and seek the views of patients on a regular basis. This would enable them to monitor their performance against these.

The practice could implement a whistleblowing policy for staff to report concerns.

The practice could develop a clear audit system to ensure emergency drugs kept are in date. The practice could develop a clear system for monitoring fridge temperatures to ensure they are checked daily.

The practice could carry out regular fire drills to ensure staff know how to deal with an emergency situation.

The practice could continue to develop Human Resources (HR) policies, particularly around safe recruitment. There could be more engagement with staff on their job descriptions and responsibilities.

The practice could develop a system to ensure patient's clinical results are assessed by another GP when one is not there, to ensure there is no delay in people receiving their results.

Good practice

Our inspection team highlighted the following areas of good practice:

A chaperone service was offered for GP home visits as well as consultations, meaning people could feel safe and supported at all times.

Patients with long term conditions were involved in their treatment choices, and had input into the development of their care plans.

The GP attended peer review and protected learning time (PLT) sessions at a neighbouring practice, where systems such as referral letters were peer audited and best practice shared.

Duddon Valley Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP, and the team included two further CQC inspectors. We also took specialist advice over the telephone from a CQC pharmacy inspector.

Background to Duddon Valley Medical Practice

Duddon Valley Medical Practice serves 3,600 patients in rural West Cumbria from their two surgeries at Kirkby in Furness and Foxfield Rd, Broughton in Furness, both of which were inspected as part of the inspection process. Patients register with the practice and can then choose which surgery to attend or where to collect their medicines from. Each surgery has a dispensary. There are usually two GP's at the practice, however at the time of inspection one was off on long-term leave with no known return date, so the practice had one full-time male GP and a female locum GP 2 days a week. Both worked across the two surgeries.

Both surgeries have car parking facilities, disabled access and disabled WC's. Child immunisation, health visitor and antenatal clinics are regularly held. There were two practice nurses who provided clinics on long term conditions such as asthma and diabetes.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We reviewed these five questions during an announced inspection on 1 May 2014. During our visit we spoke with a range of staff including the GP, nursing staff, dispensers, receptionists and administrative staff. We observed how patients were treated when they arrived at the surgery, and reviewed a wide range of records in relation to the safe running of the practice. We also spent time speaking with seven patients, and reviewed 15 CQC comment cards which patients had filled in. These had been made available in each surgery as part of the inspection process.

Are services safe?

Summary of findings

Overall we found this service was safe. There were effective systems in place to record and report allegations of abuse, and staff could describe their roles in these processes.

The practice had policies and procedures in place to ensure that the surgeries, instruments and equipment were kept clean and did not present an infection control risk. Medicines were managed safely. There were systems in place to record and investigate incidents. Staff were trained and able to respond to emergencies.

Our findings

Safe Patient Care

The practice had recently completed an exercise in which policies relating to the management and safe running of the practice had been updated or drafted. These policies covered topics such as confidentiality, consent, equal opportunities, complaints, and availability of chaperones. There was also a complaints policy. We saw that staff were aware of how to operate in accordance with those policies, to ensure the safe running of the practice and protect patients

There were effective systems in place to record and report safety incidents or allegations of abuse, and staff could describe their roles in these processes.

Learning from Incidents

There was an open culture at the practice with all staff willing and keen to learn, with one staff member saying "It's my duty to be open and honest, and if necessary critical". Staff we spoke to were not afraid to admit they had made a mistake and felt they could comfortably discuss this with other staff and the GP.

Some learning from incidents and improvements to systems had taken place. For example, the dispensaries on both sites recorded any near misses such as wrong medications or wrong doses. Monthly meetings with staff from both branches were then held where these were discussed and solutions suggested. We saw some examples of lessons learned, for instance a change in the rotas so one dispenser checked the others work. Previously dispensers had double checked their own work which was not best practice as more mistakes could go unnoticed. Patients had not experienced harm due to any errors.

This system however, worked in relative isolation from the rest of the practice, and there had been no detailed analysis to look at whether the number of incidents was high in relation to work levels, and whether any trends could be spotted.

The GP when asked was unaware of any significant events, although on asking other staff we were supplied with three incidents. The practice had carried out some investigations, attempted to find causes and learn from the incidents. However, it was not always clear who had been present, what feedback had come from whom, and who

was explicitly responsible for actions going forwards. This did not allow for a system of transparent continuous learning. The new Practice Support & Training Consultant had identified this as an area that needed improvement and had developed an action plan with time limited targets for achievement.

Safeguarding

The practice had safeguarding policies for the protection of children and vulnerable adults. The majority of staff had recently been trained on safeguarding, and were able to describe types of abuse and what they would do if they saw a patient where this was suspected. However, staff were unable to show us any flags on the system for vulnerable adults or looked after children, which would enable GP's to be alert for risks during consultations. The full-time GP was the designated safeguarding lead. In the event of the lead not being available, contact names and numbers for the Local Authority were available so staff could access them at all times to report a safeguarding event. This meant that staff could spot and appropriately respond to suspected abuse.

There was no whistleblowing policy in place for staff to raise concerns, although the Practice Support & Training Consultant told us this was shortly to be drafted. There had been no safeguarding incidents against which to monitor the system, although the GP was able to describe his involvement in a past event and accurately explain how the practice would follow procedures.

Monitoring Safety & Responding to Risk

Safety alerts or new practice guidance were received by a designated point of contact who then sent these on to appropriate staff. Staff confirmed they received alerts and new guidance as required so they were aware of any new risks to patients. Actions taken or changes in policy as a result were discussed at clinical review meetings. Staff also received a daily bulletin on the computer system so that any important information could be shared.

Both surgeries had emergency equipment such as oxygen and defibrillators, and staff had received training in their use and CPR (emergency resuscitation) training each year. Staff knew where to locate emergency equipment.

We checked emergency drugs at both surgeries. These were correct at the Kirkby surgery, although staff were unsure how to locate these and we were initially directed to the wrong drawer. At the Broughton surgery the GP had available some emergency drugs, however these were out of date. This meant that appropriate checks of these had not been carried out.

Medicines Management

There were safe systems in place for medicines management. We spoke with the dispensers, who were able to explain how they checked deliveries were correct when medicines arrived, and how they then stored these and kept totals of what medicines were in stock. There were check points throughout the process, for instance a computer alert flagged a patient who would not be allowed a repeat prescription until their medication had been reviewed by a GP.

Prescriptions were double checked by two dispensers before being given to the patient. Vaccines and refrigerated medicines were kept in lockable fridges. There was a system for temperature monitoring, although at the Broughton Surgery this had failed as the person responsible had been on holiday for several days and no-one had carried out the checks in their absence, as there was no clear procedure set out for whose responsibility it was. There were also several missed entries for the fridge temperature checks in the treatment room at Kirkby. This meant the practice could not always show that medicines had been kept safely.

There was no thermometer in the dispensaries themselves, to ensure that the other medicines were kept below 250c as per manufacturers normal recommendations. This would ensure that medicines were still fully effective when given to the patient.

Staff we spoke with had received appropriate training in safe management of medicines, and ongoing extra training was available.

Controlled drugs were kept in a separate lockable cabinet. There was a separate register for controlled drugs but this was in a loose leaf binder. The provider may wish to note that best practice guidance is for this to be in a bound book format, where pages cannot be easily removed.

There were appropriate arrangements in place for the disposal and destruction of unused medicines.

Are services safe?

Cleanliness & Infection Control

Both surgeries were clean and tidy at the time of our visit, and patients told us they did not have any concerns about cleanliness of the practices. Patients commented "spotless premises" and "it has always been clean and hygienic".

There were wash hand basins, hand wash and paper towels available for staff and in the public toilets. This meant people could wash their hands properly and lessen the risk of spreading germs.

Disposable paper covers were used on top of treatment benches, and the benches were wiped between patients, meaning there was less chance of infection spreading. The provider may wish to note that one treatment bench at the Kirkby surgery was worn at the edges and would not be able to be cleansed effectively.

Only single use instruments were used for all procedures, such as minor operations, and clinical waste bins and sharps bins were available for their disposal. We checked equipment and dressing packs and these were in date and in their sterile wrappings. There was a system in place to audit stock and dispose of any that were out of date.

Staff were able to describe precautions they took to minimise spread of infection, such as cleaning equipment after each patient, and using personal protective equipment (PPE) such as rubber gloves when carrying out procedures on patients. We saw cleaning schedules in place for all areas and these had been completed correctly by staff. A designated staff member checked the cleanliness of the surgery and discussed any issues with the cleaner who worked two days a week across both practices. The cleaner confirmed that she had enough cleaning materials to carry out her job and a supply of gloves and aprons available to her.

There was a procedure for the control of infection that included guidance regarding spillage of biological substances, taking blood, handling samples, disposal of sharp needles/instruments, needle-stick injuries, decontamination and disposal of materials and transportation of biological clinical waste. This meant that staff had access to and could follow appropriate guidance. The procedures was supplemented by cleaning schedules and an infection control audit tool to monitor the effectiveness of cleaning.

Staffing & Recruitment

The practice had carried out an assessment of staffing levels, and at the time of our visit staff did not appear to be unduly rushed or pressured. Staff said they had time to complete their tasks. We looked at staff rotas and saw all designated shifts were covered.

Staff told us there were enough staff employed to cover shifts and holidays, and they would never leave the practice short and would do extra shifts to cover unexpected sickness. Nurses said they covered for each other so there was never a need to use agency nurses.

The GP described how the service could anticipate changes in demand caused by, for instance, bad weather or bank holidays, and make extra appointments available.

The service was currently using a regular locum doctor from an agency due to one partner GP being absent. The second GP was unclear what the service would do in the event of the second partner becoming unavailable, or the first partner not returning.

Dealing with Emergencies

Staff told us that fire safety procedures had been refreshed at a recent practice meeting, although we could not find evidence that actual fire drills had ever been carried out.

Due to running two surgeries, with staff working across both, the provider was able to operate an emergency response system where staff would relocate from whichever surgery was out of action. This meant there was an effective plan in place to continue delivering services to patients in the event of an emergency.

Equipment

There were procedures in place to ensure that equipment was checked and functioning correctly. Equipment such as the spirometer machine (which measures breath for lung conditions) was calibrated regularly. Staff were trained and knowledgeable in the use of equipment for their daily jobs. Electrical equipment safety checks had recently been carried out.

Are services safe?

Most equipment was duplicated across the two surgeries so emergency back-ups were available. Items of medical equipment were on service maintenance contracts where necessary to ensure their speedy repair or replacement.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found some aspects of this service required improvement. There was a system to monitor and promote clinical best practice, and staff worked with patients to develop care plans for their complex or long term conditions. There was some evidence of health promotion and identifying those at risk of ill health.

However, staff had never had the benefit of formal supervisions or appraisals, meaning their learning needs had not been identified. This could have a negative impact on patient outcomes.

Our findings

Promoting Best Practice

There was a system in place to deliver best practice clinical guidance directly by email to nurses and GP's to ensure they kept up to date. Clinical staff were aware of this system and took time to read guidance relevant to them. This was then discussed in clinical review meetings. This meant that care and treatment was delivered in line with recognised best practice or guidance.

Interviews with the GP showed he performed appropriate comprehensive examinations. Appropriate referrals were completed at the time of consultation, with a different system identifying urgent referrals. This ensured that timely investigations were carried out.

Nursing staff showed us examples of how a care plan would be put in place for a patient with a complex health need such as diabetes or asthma. These were filled in and updated in conjunction with the patients to ensure the patient was involved in, consented to and understood their treatment. Staff were able to explain how they would involve carers and take decisions in the best interest of the patient if they were unable to consent.

Management, monitoring and improving outcomes for people

The practice participated in some clinical audit and peer review, leading to improvements in clinical care. For instance, the prescribing policy had been updated to reflect best practice guidance.

Nurses had fortnightly clinical meetings and met with the GP once a month to promote clinical best practice. The GP attended peer review and protected learning time (PLT) sessions at a neighbouring practice, where systems such as referral letters were peer audited and best practice shared. The practice participated in the Quality and Outcome Framework to allow them to assess patient outcomes over time.

However, we did not find that performance information on patient outcomes was available to the public or patients, for instance via the practice website. This meant new patients could not make an informed choice, and existing patients were not able to compare their service to others.

Are services effective?

(for example, treatment is effective)

Staffing

Staff had never had a formal appraisal or supervision, as historically such a system did not exist. The GP attended peer review, and nurses met with the GP and amongst themselves, however there was no system for other staff to identify their learning needs or address poor performance. The practice had recently employed the services of a Practice Support & Training Consultant , and much progress had been made on implementing new systems. Staff were currently in consultation to develop clear job descriptions, roles and responsibilities. However an appraisal or supervision system was not yet in place and the first appraisals were not scheduled to take place until September 2014. This meant that the skills and learning needs of staff were not being appropriately monitored, which could have a negative impact on patient outcomes.

Systems to manage staff performance such as disciplinary and grievance procedures were still in draft format, however progress was being made in developing these as the consultant explained these had previously been absent.

Staff said they were now encouraged to take up training opportunities, and basic mandatory training such as safeguarding, moving and handling, basic life support and fire safety had been completed. Individual learning needs for different staff had not been completed.

Recruitment checks had been carried out on the locums used by the practice. This information had been supplied through the locum agency. This included checking the doctors were registered, DBS (criminal records) checks and indemnity insurance.

There had not been appropriate checks carried out for other staff employed at the practice. Staff files of people employed since the practice registered with CQC consisted only of an application form and an acceptance letter, and no references or DBS checks had been sought before the person was employed. The practice had also not carried out a risk assessment to see if criminal records checks needed to be carried out for non-clinical staff. This meant that people could be put at risk as the practice had not satisfied itself that people were appropriate to work at the practice. The Practice Support & Training Consultant had identified this as a problem and DBS checks had been applied for, for all staff, and the results were awaited. We discussed with the consultant about seeking references retrospectively or staff making a statement on file.

We found the practice had no formal induction process in place for its newly recruited staff, although a recently recruited member of staff told us they had worked for approximately three weeks alongside another member of staff, to be given training in reception and administrative duties. This person was acting as their mentor throughout their probationary period. We asked if the new employee had received formal feedback at the end of their probationary period. We were told they had not. This meant the new employee had not had their performance formally reviewed, and areas of training need had not been identified.

The GP was a year behind with his professional appraisal and revalidation programme. Following the inspection, the provider told us that this appraisal had now been booked for the same week. The provider accepted he had relied on a system of external bodies telling him when his appraisal was due, and when this system had failed he had not chased it up himself.

Working with other services

Details of any out of hour's consultations from the previous night were shared with the practice next morning. These were faxed to the surgery and the GP reviewed these first thing each morning, and if necessary followed up any actions. This ensured that any urgent consultations were seen that day. The consultations were then entered on the system with flags where necessary for the GP to follow up.

We saw examples of good practice for the management of long term conditions. For example the practice nurses worked closely with hospital consultants, dieticians, and specialist lead nurses to promote continuous improvement in the management of diabetes.

Regular clinical consultations on long term conditions were held between the GP and nurses. The GP had approached local practices to work co-operatively but this was still being developed.

We spent time speaking with patients and were able to confirm further examples, for instance that GP's and

Are services effective?

(for example, treatment is effective)

midwives worked together and involved specialist consultants if pregnant women had an underlying health condition. This meant that steps were taken to ensure care during pregnancy would be safe and effective.

Health Promotion & Prevention

A full medical history was taken from new patients, including lifestyle factors such as smoking, and they were also offered a new patient consultation when registering with the practice.

The computer system had prompts built into it for staff to contact patients to come in for health checks related to their condition. This also captured some information on people at risk of developing a long term condition. Care plans had sections within them to monitor patients mental health due to the risk of depression associated with long term illness. This then enabled the nurse to identify this risk and refer the patient to support services.

In the waiting area of the surgery, we found information posters and leaflets promoting different services and clinics held at the practice, for example medicines review clinics and diabetes clinics. People could be given referrals where required to the local smoking cessation service. There were also health prevention clinics such as childhood immunisation and flu clinics.

Are services caring?

Summary of findings

Overall we found this service was caring. Patients spoke highly of the GP's and staff and said the service was kind, caring and compassionate, and that they were treated with respect. We confirmed this during our observations of staff.

Our findings

Respect, Dignity, Compassion & Empathy

There were glass screens around the reception desks in an attempt to improve patient privacy, although in both surgeries the size of reception and waiting areas necessarily limited improvements the practice could make. We asked the receptionist how they would accommodate patients who wanted to speak to someone in private. They told us they would take the patient into a private room away from the reception area so they could talk freely and not be overheard.

There were notices prominently placed on the walls in the waiting rooms offering patients the option of using a chaperone. This service also extended to home visits made by the GP, which was good practice.

We saw that reception staff were polite and friendly, and chatted with patients as they came in. Staff knew patients, and frequently greeted patients by their names. We did receive on the comment cards a minority of negative comments about the attitude of some reception staff, although one person also said that staff attitude and the atmosphere in the surgeries had improved in recent months.

People we spoke with said "all the staff are smashing. We all know each other, I like that, they are all very pleasant." Other feedback received from patients included "I find all the surgery staff courteous and efficient", "I have nothing but praise for the service provided" and "yes, always, always treated with dignity and respect".

Treatment and consultation rooms were lockable and had a privacy curtain around treatment benches.

We saw that the GP was empathetic and caring towards patients, and we received almost entirely positive feedback from patients. Comments included "Both Dr's are very good, from the experience I have had they cannot do enough for you, they are very caring". People said they were given sufficient time during consultations.

During the inspection, we became aware of several further examples of the GP on duty showing a caring, compassionate attitude, including voluntarily making himself available out of hours, without pay, to provide continuity of care for terminally ill patients. The GP knew patients personally and enquired after people's relatives.

Are services caring?

One staff member said “What matters to us is that the patients come first and that we be the best practice we can”. Staff described how they handled sensitive matters with tact, for instance referring to a male doctor if a male patient preferred, rather than having a nurse consultation with the female nurse.

Staff were heavily invested in their jobs and in the community the practice served, and throughout the inspection showed their drive to provide a compassionate, caring service.

Involvement in decisions and consent

We saw several examples of good practice, particularly for the management of long term conditions such as diabetes. Nursing staff showed us examples of how a care plan would be set up. These were patient centred and asked the patient what was important to them, and what they wanted to achieve from treatment. These forms were sent out before the consultations to give the patient time to think about their answers.

The process was patient led and together the patient and nurse would negotiate a care plan dependent on what outcomes the patient wanted to achieve. The frequency of attendance at appointments was also negotiable to the patient. Feedback from patients included “The practice nurses ensured I was informed of my results and checked that I knew what my tablets were for”.

Some female patients and their partners told us they felt involved in the preparation for the birth of their babies, and were happy with the process. People told us they had opportunity to discuss their care and diagnosis given.

There was no hearing loop at reception for patients hard of hearing, and staff had only a vague awareness of telephone interpreter lines for those whose first language was not English. These were not advertised in the waiting areas and the information was not readily available for staff. While the practice had assessed there was not a great need in the local area for interpreting services, this meant that staff were not best placed to help someone access the practice who did not speak English.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall we found the service to be responsive. People could generally access the service when required. Sufficient numbers of appointments were available, and people could request telephone appointments or home visits. In general, people were supported with timely referrals and to receive their results.

Our findings

Responding to and meeting people's needs

We looked at the minutes of team meetings, which showed the provider wanted to develop a system to proactively identify patients in vulnerable circumstances.

At this point in time there was a female locum GP at the surgeries two days a week, but there was no long term plans to retain a female GP if the other male GP partner returned. Although we did not receive specific feedback from patients on this issue, it did mean patients in future could not exercise choice, other than to visit a different practice. It was not known how long the female locum GP was to be engaged by the practice for.

Carers and support services for vulnerable groups were advertised in each waiting room. Each surgery had disabled access and plans were in place to make the counter at the Kirkby surgery more wheelchair user friendly. Nursing staff described how they wished to develop a system for more visits for people with long term conditions who may struggle to get into the surgery. Waiting rooms were comfortable with adequate seating.

Access to the service

All results such as blood tests came into the practice via email and were looked at each morning by the GP. However there was not a clear procedure in place for who looked at these if the GP wasn't there, and the locum had not been instructed to look at them. The GP described returning to a backlog of results after a holiday which had taken him longer than usual to clear. This meant that patients were sometimes not receiving a timely diagnosis or news of their results.

The 'choose and book' system, which gives patients a choice of hospital, was offered at the time of consultation. Referral letters were typed up the same day and re-checked by the GP before being sent. This meant that the practice supported patients in making timely appropriate referrals.

Patients said "Never a problem getting an appointment, they can always squeeze me in after work", "minimum problems getting appointments" and "I have also been able to have telephone consultations and have received home visits when necessary". The practice had a policy to

Are services responsive to people's needs?

(for example, to feedback?)

see children the same day, and several appointments were blocked off each day for urgent conditions. People told us it was easy to get through on the telephone to book an appointment, and the waiting time for an appointment was not excessive. People we talked to who worked during the week, told us the surgery effectively met their needs, offering appointments early in the morning and staying open up to 6.30pm in the evening at the Kirkby surgery.

Sufficient numbers of appointments were available and throughout the day patients accessed the service without difficulty, for instance when requesting a review appointment following consultation. Phone and home visits were also available as requested. In this way patients could access all services as required. The practice nurse was also available to see people for drop-in clinics or for appointed consultations throughout the day. The nurse then referred people to the GP if they presented with symptoms that required they be seen by the doctor immediately.

Both the practice leaflet and website were out of date and referred to staff who no longer worked there. This did not support people in how to access the service.

Concerns & Complaints

There was a suggestion box on the wall in each surgery, and patients we spoke with knew how to raise a complaint. We saw evidence of learning where a complaint had been raised about a lack of appointments at the Kirkby surgery, and the number of appointments had been increased as a result.

The complaints procedure had recently been updated. There had only been one formal complaint received in the last 12 months, and this had been dealt with effectively as it had received investigation, a full written response, and learning took place as a result.

There was not an active patient participation group at the time of our inspection, which would have given more insight into patient's views, however one was being developed. It had been recognised that the practice needed to be more proactive in seeking people's views and monitoring them.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Overall, we found the service showed some characteristics of being well-led. The practice had employed the services of a Practice Support & Training Consultant, in recognition of the fact that many policies and management procedures had been previously absent. We found that much progress had been made, and staff were engaged with this process. The practice still needed to develop clear roles and responsibilities for staff and communicate a clear vision statement for the future.

Our findings

Leadership & Culture

All the staff we spoke with described a previously negative culture, and said that since staff had changed there was now an open, friendly, blame-free culture. The practice had a 'Practice Commitment' information sheet for patients which outlined the services they should expect to receive. Staff were able to describe their personal values and ethos for the practice, however much of this was informal and not a reflection of any published mission statement or objectives. Team meeting minutes we saw asked staff to contribute to developing a mission statement for the organisation.

The staff team appeared to be supportive and encouraging of each other. Further work needed to be done in developing staff roles and responsibilities, and staff told us they would like to be more involved with this. There was also no clear HR policies around safe recruitment. The lack of supervisions and appraisals meant that there were not sufficient mechanisms in place to deal with poor performance.

Cover arrangements were in place to cover the GP who was absent however, this was only a short term measure. It was not known whether the GP would return, and there were no clear succession plans in place for this.

Governance Arrangements

An organisational chart had been produced to show clear lines of responsibility. This showed the current GP as the main leader, however when asked on how he planned to develop his leadership capacity alongside his clinical role, the GP was not clear. We discussed leadership skills and courses with the GP.

The GP and Practice Support & Training Consultant both welcomed openness and constructive challenge from staff, and this was confirmed when we spoke with staff. Staff said they felt confident bringing up issues, and that they would be acted on. Although the staff team generally appeared to work well together, staff were sometimes unclear as to their specific roles and who was responsible for decisions. We saw an example of a significant event in which confusion

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

among staff had occurred, and staff felt they were asked to make a decision above their level of training. This had been discussed and reviewed as to why this incident had occurred.

The provider had taken some steps to ensure high quality care was consistently delivered, for instance a locum doctor was used to cover one GP's absence. The provider explained they tried to always get the same locum, so they were familiar with the patients

Systems to monitor and improve quality & improvement

The practice had in place some systems for performance and quality management, including monitoring of complaints, clinical audits, cleanliness audits, and health and safety risk assessments. The practice also monitored quality and performance through administrative audits. The practice participated in the Practice Quality Framework Schemes for Referral Support and Medicine Optimisation, which involved audit working with the practice support pharmacist.

Patient Experience & Involvement

The practice last carried out a patient survey in 2009, and the practice historically had not engaged proactively with patients. However this was recognised as a problem area where the practice wished to grow. Informal 'Meet the Patient' events were being planned, and the practice manager told us they had recently established a patient participation group. This group was to represent the wishes of the patients who used the practice and be used to help organise future patient surveys.

Staff engagement & Involvement

Staff said the culture in the practice had recently been much improved, and they now felt able to raise concerns freely, and that these would be listened to. The practice had made much progress prior to the inspection in identifying issues, such as a lack of HR policies, and putting action plans in place to address these.

We saw minutes from practice meetings where staff had been able to feed ideas in and learning from incidents was discussed. One staff member said "there's lots of opportunity to feed into the practise now, and we are getting a lot more support". There were regular clinical meetings between nursing staff and GP's, and further practice meetings were planned.

Staff on the whole were observed to be enthusiastic and invested in the practice's future, as they said the practice was now able to move forward into a more positive future. Staff were still at times unsure of their roles and responsibilities, and were in discussion with the practice manager to clarify these.

Learning & Improvement

The Practice Support & Training Consultant told us taking minutes of practice meetings had only recently been made a routine requirement. The practice had recognised that this represented a previously missed opportunity to record action points and measure progress in any areas identified for improvement.

There were management systems in place for safe dispensing and prescribing of medicines, and we saw where the system had been improved with input from staff following near misses or incidents. This meant that learning took place. A lack of staff objectives linked to a clear appraisal system had been recognised as a problem, but action had not yet been taken to implement a system.

Identification & Management of Risk

Staff knew the patient population well, and staff were aware of most of the risks to the practice. The uncertainty over the future workings of the GP partnership presented a risk, as to whether the other partner would return or alternative permanent provision would be needed. This lack of succession planning had been recognised, and the Practice Support & Training Consultant was working with the GP to develop future plans.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have arrangements in place to ensure that persons employed for the purpose of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely, including through an appropriate system of supervisions and appraisals.**