

Springcliffe SurgerySpringcliffe Surgery

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

Springcliffe Surgery provides general medical services to a population of 2,439 registered patients in the city of Lincoln. The surgery has three consultation rooms on the ground floor which can be accessed by patients with a disability. The service is provided by a team of five GP partners, nursing and administrative staff who also work at a larger GP practice registered separately.

Improvements were needed to ensure the service is safe.

Most of the systems in place at the practice to monitor the safety of the service were effective. This included the management of safety incidents, infection control and prevention, emergency situations and the recruitment of appropriate staff. There was an appropriate system in place to work with other agencies to safeguard vulnerable children. However, a similar system was not in place to ensure the safety and protection of vulnerable adults and this required improvement.

The services were effective.

The practice had effective methods in place to monitor the clinical needs of their patients and ensure they received relevant care and treatment to keep them well. Best practice guidelines were followed although the systems to share best practice updates with the staff team could be further strengthened. Procedures for staff recruitment, training and development ensured that all employed staff had the right skills for their role. However, improvements could be made to ensure that the procedures were fully completed. The practice demonstrated they had effective professional relationships with other services.

The services were caring.

We spoke with seven patients who told us the staff always treated them with respect and considered their individual needs. Most patients were involved in decisions about their care and treatment and staff ensured they found answers to any questions they were unable to answer. However, we were concerned that staff did not know how to access translation services for patients who spoke little

or no English so that they could be certain patients could make decisions and choices about their care and treatment. We have asked the practice to make improvements.

The services were responsive to patient's needs.

The staff were responsive to individual patient needs and we saw evidence to support this. However, the practice had not considered the needs of the growing European population in terms of communication and provision of information. The number of registered patients was increasing and this placed more demand on the appointments system and some patients told us they had difficulty accessing an appointment when they needed one. The practice had commenced their first patient survey which included questions about the appointments system to help them review current arrangements. A low number of complaints had been received about the practice. Each one had been considered, investigated and an appropriate response provided.

The services were well-led

There was a structure in place to support leadership and management of the service. Staff told us the team worked well together and that senior staff were approachable although some staff groups did not have the opportunity to engage with the senior team to discuss and contribute to service improvements. Staff received informal support, regular training and an annual appraisal although not all staff had received an appraisal at the time of our inspection. Monthly business meetings involved GPs, nurses and senior administrative staff and addressed a range of quality issues effecting the day to day management of the service. Some clinical and non clinical audits took place but there was no overarching audit plan to engage the team and ensure that quality was being measured, reviewed and improved to benefit patients who used the service. Risk management procedures were in place.

The practice was able to demonstrate that they used feedback from complaints to improve the service.

Summary of findings

The practice must take action on one issue where we found that improvement was needed;

The systems used by staff to identify, protect and support vulnerable adults who were at risk of abuse or were

experiencing abuse were not adequate. This was because staff had limited knowledge about the actions they should take if they suspected that a patient was at risk of, or experiencing abuse.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were needed to ensure the service is safe.

Most of the systems in place at the practice to monitor the safety of the service were effective. This included the management of safety incidents, infection control and prevention, emergency situations and the recruitment of appropriate staff. There was an appropriate system in place to work with other agencies to safeguard vulnerable children. However, a similar system was not in place to ensure the safety and protection of vulnerable adults and this required improvement.

Are services effective?

The services were effective.

The practice had effective methods in place to monitor the clinical needs of their patients and ensure they received relevant care and treatment to keep them well. Best practice guidelines were followed although the systems to share best practice updates with the staff team could be further strengthened. Procedures for staff recruitment, training and development ensured that all employed staff had the right skills for their role. However, improvements could be made to ensure that the procedures were fully completed. The practice demonstrated they had effective professional relationships with other services.

Are services caring?

The services were caring.

We spoke with seven patients who told us the staff always treated them with respect and considered their individual needs. Most patients were involved in decisions about their care and treatment and staff ensured they found answers to any questions they were unable to answer. However, we were concerned that staff did not know how to access translation services for patients who spoke little or no English so that they could be certain patients could make decisions and choices about their care and treatment. We have asked the practice to make improvements.

Are services responsive to people's needs?

The services were responsive to patient's needs.

The staff were responsive to individual patient needs and we saw evidence to support this. However, the practice had not considered the needs of the growing European population in terms of communication and provision of information. The number of

Summary of findings

registered patients was increasing and this placed more demand on the appointments system and some patients told us they had difficulty accessing an appointment when they needed one. The practice had commenced their first patient survey which included questions about the appointments system to help them review current arrangements. A low number of complaints had been received about the practice. Each one had been considered, investigated and an appropriate response provided.

Are services well-led?

The services were well-led.

There was a structure in place to support leadership and management of the service. Staff told us the team worked well together and that senior staff were approachable although some staff groups did not have the opportunity to engage with the senior team to discuss and contribute to service improvements. Staff received informal support, regular training and an annual appraisal although not all staff had received an appraisal at the time of our inspection. Monthly business meetings involved GPs, nurses and senior administrative staff and addressed a range of quality issues effecting the day to day management of the service. Some clinical and non clinical audits took place but there was no overarching audit plan to engage the team and ensure that quality was being measured, reviewed and improved to benefit patients who used the service. Risk management procedures were in place.

The practice was able to demonstrate that they used feedback from complaints to improve the service. However other methods of feedback had not been developed because their patient group was newly formed and had not had a meeting at the time of our visit.

Summary of findings

What people who use the service say

We spoke with seven patients during our visit to the practice. They told us they received a good level of care and support and were always treated with care and respect by the staff. Some of the patients told us they had difficulty getting access to appointments when they wanted them. Another patient with a long term condition told us they were able to plan their appointments in advance so they could see their preferred GP who knew them well. Another patient with a young child said they were always able to get an appointment for their child and they felt able to phone for further advice after an appointment if they needed to.

The practice had recently formed a patient participation group (PPG) to represent the views of the registered patients and work with the practice to shape and inform

improvements. A patient feedback survey was in progress. Although we met some of the group members, they had yet to have the first meeting to establish their role and responsibilities.

We received three comments cards that complimented the friendly, caring and professional staff. Two patients said they had experienced problems getting an 'on the day' appointment, one of them because it was difficult to fit in an appointment around their work schedule.

The practice supported people who lived in four local care homes. We spoke with all of the home managers who valued the support that practice staff provided to people who lived in the care homes. They were always seen in a timely manner, staff were friendly and shared relevant information so that people could be provided with effective care and support.

Areas for improvement

Action the service **MUST** take to improve

Staff must receive guidance to ensure they know how to report an adult safeguarding concern.

Action the service **COULD** take to improve

- Review the provision of bins for the disposal of paper hand towels, cleaning procedures for fabric chairs and materials for cleaning the baby change facility in between use.
- Improve recruitment records to demonstrate that applicants had proven their suitability for the role during their interview process.
- Staff did not know how to access translation services so that patients with a limited use of the English language were able to make informed decisions about their care and treatment.
- Review the process for checking patient test results on a daily basis.
- Review the information available to patients who may have a disability about how to access the building.
- Given that appointment time was wasted, further action could be taken by the practice to reduce the number of did not attend (DNA) appointments and make best use of the available appointments.
- Review the role and staffing in reception to ensure that patients receive timely responses on arrival and when telephoning the surgery.
- Ensure that all audit findings are reviewed, actions are taken and changes put into practice result in sustained improvements.
- Review the whistleblowing policy to include the named member of staff with overall responsibility for managing any whistleblowing issues and information for staff on how to seek support from outside the workplace.
- Ensure that information on how to raise complaints or concerns is more accessible for patients.

Good practice

Our inspection team highlighted the following areas of good practice:

Summary of findings

- Patients' electronic records were linked with the local hospice. This meant that records of care were shared between the services and the practice had access to timely information about any care given to their registered patients.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included an additional CQC Inspector, a specialist advisor with experience of nursing and practice management and an expert by experience. This is a person who has personal experience of using this type of service.

Background to Springcliffe Surgery

Springcliffe Surgery provides general medical services to a population of 2,439 registered patients in the city of Lincoln. The surgery has three consultation rooms on the ground floor which can be accessed by people who may have a disability. The service is provided by a team of five GP partners, nursing and administrative staff. This was the first CQC inspection since the service registered in March 2013.

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 30 April 2014. The inspection took place over one day and was led by a lead inspector with assistance from a GP. A practice management specialist advisor, a second inspector and an expert by experience were also part of the inspection team.

During our visit we spoke with six staff. This included the Practice Manager, a GP, reception and nursing staff. We also spoke with seven patients who used the service either in person or by phone. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed three comment cards where patients and members of the public shared their views and experiences of the service.

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)

Detailed findings

- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 30 April 2014.

During our visit we spoke with a range of staff, including GP's, nurses, managers and administrative staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Summary of findings

Improvements were needed to ensure the service is safe.

Most of the systems in place at the practice to monitor the safety of the service were effective. Safety incidents were mostly well managed and any learning from each incident was shared with staff. There were appropriate measures in place to monitor the cleanliness of the surgery and prevent the spread of infection. Emergency procedures and equipment was readily available and staff knew what action to take in an emergency situation. Evidence that we reviewed demonstrated to us that appropriate procedures were in place to support the safe recruitment of skilled staff.

Although there was an appropriate system in place to work with other agencies to safeguard vulnerable children, a similar system was not in place to ensure the safety and protection of vulnerable adults. Most staff had not received any training in how to recognise or report abuse of vulnerable adults. There were no effective procedures in place to ensure that allegations of abuse or known concerns for any registered patients were effectively managed in line with national and statutory guidance.

Our findings

Safe patient care

We looked at evidence and spoke with staff to see how they ensured that safe patient care was being provided.

We found the practice had reviewed the systems they used to ensure that patients' personal information was safely managed and held securely. The reviews demonstrated that their systems were effective.

There was a system in place to identify any errors or safety incidents that was mostly well managed. However, we identified a medication error that had not been reported and investigated correctly. The error had not resulted in any harm to the patient and we found that there was a brief record that the member of staff who made the error had discussed it with their line manager. However, it was not formally raised as a significant event and we found the practice manager was unaware that it had taken place. This meant that any safety procedures were not reviewed with the practice team so that changes to limit the risks of a similar occurrence could be put into place.

Learning from incidents

The practice had clear systems in place for identifying, reporting and investigating incidents or significant events and this included any medication errors. Minutes of meetings we reviewed demonstrated that these were shared and discussed at practice meetings so that any learning influenced changes to their systems and practices.

Overall, we found that the opportunities for learning from any incidents or near misses were identified and well managed. For example we saw an incident that related to giving consent to share information. This was investigated, discussed at a meeting, learning was shared with staff and changes were put in place. However, the medication error that we identified and had not been investigated correctly by staff, resulted in a missed opportunity to learn from the incident and review staff competence.

Safeguarding

The practice had a named member of staff to lead on child protection issues. There was also a policy in place to guide staff on the procedures to take when any concerns arose in relation to safeguarding children. When we checked training records and spoke with staff we found that they had completed child protection training and were

Are services safe?

knowledgeable about their role and any actions they should take. An alert was placed onto the patient record system so that staff were made aware of any known safeguarding concerns when they treated a patient.

However, we found that staff had not received training in safeguarding vulnerable adults, did not know which member of staff had the lead responsibility and were unaware of the reporting process if they had a concern. Staff had no process for identifying patients on their records system who were known to have safeguarding issues so that staff were alerted to concerns when they treated the patient. When we checked the policy for safeguarding vulnerable adults we found that the practice did not have their own local policy and what they had in place had been provided by the local health team in 2009.

The practice manager informed us the policy was being developed and confirmed that level 3 training for clinical staff had not yet taken place as they had not been able to find a relevant course.

The practice had a whistleblowing policy in place although this did not include information on who had overall responsibility for managing any whistleblowing issues within the service, or how to seek support from outside the workplace.

Monitoring safety and responding to risk

There were an appropriate number of appointments made available to patients at the surgery. When a doctor was not available on two afternoons each week, provision was in place for dealing with patients who had urgent needs that required medical attention that day. Emergency procedures and equipment was readily available and staff knew what action to take in an emergency situation.

A nurse practitioner provided a clinic one afternoon a week when there was no doctor on site. Two part time practice nurses and a health care assistant supported the GPs and ran a range of patient clinics that included immunisations for children, health checks and specialist chronic disease management. We looked at five files for clinical staff and saw evidence that they had completed relevant training. There were also plans in place to ensure they had on going professional development so that staff had sufficient skills to fulfil their roles.

One member of staff told us the numbers of the patients registered at the practice were increasing and an additional

nurse had been recruited to work between the two locations although more of their time was to be spent at Springcliffe Surgery. This meant the practice were increasing levels of staff to help meet patients' needs.

The practice manager informed us that they did not carry out any needs analysis in relation to staffing but they felt they met patients' needs. There was no evidence to demonstrate that the practice ensured there were sufficient staff in place with the right range of skills to achieve this.

Medicines management

Springcliffe Surgery had clear and safe systems in place for issuing prescription renewals for patients who took long term medication. We looked at two medications errors that had been identified and well managed showing that learning points had been noted. One concerned a prescribing error made by practice staff, the other an error made in a patients prescription supplied from the hospital.

Cleanliness and infection control

When we inspected the premises we saw that staff had access to appropriate hand washing facilities and these were used to help reduce the risk of spreading any infections.

The premises were cleaned by an external contractor whose staff completed a cleaning schedule each day to demonstrate the work they had completed. The practice supplied us with evidence that four staff employed by the contractor to clean at the surgery had completed infection control training in February and March 2014. The practice also supplied two audits of cleaning completed in the last two months which demonstrated that the cleaning had been completed to a satisfactory standard.

We found that staff and patient toilets were well stocked with appropriate hand wash facilities but there were open top waste bins for the disposal of paper hand towels in some areas. This did not follow best practice guidelines. In addition, the baby change unit was not supplied with protective disposable liners or hygiene wipes to ensure the changing area could be cleaned after use.

Overall we found the premises were visibly clean and tidy. We noted there was a toy box in the waiting room and when we checked, we saw records that the toys were cleaned each month. However, the check did not include a

Are services safe?

safety check and we found a toy with the batteries taped in place. Most of the seating in the waiting room could be wiped clean but a few fabric covered chairs were also in use which were more difficult to clean.

A member of staff had responsibility for leading on infection control issues and staff knew who to approach if they had any questions about infection control. We saw evidence that the infection control lead monitored practice and shared information at staff meetings.

The practice had completed an infection control audit in July 2013 but they were unable to demonstrate that actions had been taken in response to the findings. Staff had received infection control training although records indicated that some staff were due to renew this.

Staffing and recruitment

During our visit, we noted that the staff who worked at reception were often very busy as they greeted people who arrived at the practice, dealt with telephone calls and completed some other administrative tasks. During the afternoon there was just one member of staff at reception who was trying to cover all tasks. Throughout the day at times, the queue of people waiting to speak with a receptionist built up while they attempted to respond to patients requests and answer the phone.

We looked at the files of eight members of staff and found that appropriate recruitment procedures were in place to ensure that patients were cared for or supported by suitable staff.

Dealing with Emergencies

When we asked staff, they were able to tell us about the actions they should take in the event of an emergency situation. The practice manager had reviewed a major incident plan during March 2014. This seemed appropriate and the manager planned to raise it at the next staff meeting.

Equipment

The practice took steps to ensure that the fixtures and fittings in the building were checked and regularly maintained so that the premises remained safe for patients, staff and visitors. This included electrical safety checks on equipment, servicing of fire fighting equipment and maintenance of the heating system.

Other safety checks and risks were being managed. These included water temperature and legionella tests and an annual fire risk assessment.

We found that appropriate safety checks for clinical equipment (including emergency equipment) took place on a regular basis to ensure that items were in good working order and ready for use.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

The practice had effective methods in place to monitor the clinical needs of their patients and ensure they received relevant care and treatment to keep them well. Best practice guidelines were followed although the systems to share best practice updates with the staff team could be further strengthened. Procedures for staff recruitment, training and development ensured that all employed staff had the right skills for their role. However, improvements could be made to ensure that the procedures were fully completed. The practice demonstrated they had effective professional relationships with other services.

When we spoke with the managers of four local care homes they provided very positive feedback about the support provided by the staff at Springcliffe Surgery. They all told us the service provided was very supportive and the staff responded to requests for visits in a timely way.

Our findings

Promoting best practice

During our discussion with a GP we found there was no system in place to ensure that new guidelines or research evidence was used to inform practice. Each registered professional was expected to keep their own practice up to date.

We saw some evidence that audits were completed by GPs for their own development, but there was no overall plan to support service developments. For example practice level audits to review aspects of clinical care that were delivered to patients so that improvements could be identified and changes made to improve outcomes for patients.

Management, monitoring and improving outcomes for people

The practice had registers of patients with long term chronic diseases such as asthma, depression and diabetes in place. The practice nurses reviewed these patients and were supported by the GPs in doing so. We looked at one register with a practice nurse and found that patients received full assessments and continuous monitoring of their condition to promote their health and well being. There was a recall system in place for patients to remind them to attend for their appointments. For those who were unable to leave their home to visit the surgery, home visits for management of their conditions were arranged.

The practice had achieved a 67% attendance rate for women registered at the practice who required a cervical smear test. This was lower than the national average. The GP we spoke with felt that because the recall programme was managed nationally, the surgery had no control over this. However, the practice had a high rate of patients who did not attend their booked appointments overall and this could be improved.

We saw evidence that the GPs reviewed attendance of their patients at the accident and emergency department and used this information to identify patients who may need to be reviewed. For example patients with chronic conditions who had attended accident and emergency because of problems with their disease symptoms.

When patients had a blood test or another test completed, the results were checked by the appropriate GP or another

Are services effective?

(for example, treatment is effective)

doctor if they were unavailable. We found that it was not common practice for the GPs to review test results on a daily basis. This meant there was a risk that a patient could receive a delay in getting any treatment they required.

We spoke with a GP who told us that clinical audits were carried out by individual GPs and the learning was shared with the other staff. We saw that the GP had completed audits such as the use of specific medication, palliative care audit and resuscitation orders. These had resulted in changes to practice and further re-audits had been completed to ensure that change was being sustained.

Staffing

We looked at eight files for five clinical staff and three non-clinical staff. We saw that with the exception of two members of staff (one who had been on long term sick leave and the other who was administration staff recruited within the last six months) they had appropriate criminal records checks carried out. We saw evidence of each person's employment history and references. The interview records did not always contain the information discussed during the interview to support the decision that the person was suitable for the role. This could be improved.

The practice informed us that staff were appraised by their line managers, which was either a GP, the nurse practitioner or the practice manager. The staff files we reviewed demonstrated that three nurses were overdue for their annual appraisal by one or two months. Two staff in administrative roles had no appraisal recorded on their file for more than a year and this needed to be addressed.

Evidence demonstrated that nursing staff carried out regular training as part of their on going professional development. All nursing staff had valid registration with the Nursing and Midwifery Council.

An induction process was in place for new staff. This included on-going training as well as having two, four and twelve week reviews completed by their line manager.

One member of staff we spoke with told us that although they had received on going training, some training was

difficult to fit into their working week. They told us the practice closed for one afternoon per week and there were still administrative tasks to be done in this time, meaning they had limited time to access online training.

Working with other services

One patient we spoke with told us their GP had good communication links with other specialist doctors who treated them regularly. The patient said this helped because the GP always gave them choices about their options for managing their medication so that joint decisions on treatment could be agreed.

Springcliffe Surgery provided support to four local care homes. We made contact with the home managers to ask them about the care and support that people who lived in the homes received. All of the homes were very complimentary about the service with one manager describing them as, "Excellent". They told us that people were always seen by a GP on the day of the request which was usually between the morning and afternoon surgeries. However, the GPs always made efforts to ensure a same day visit was completed by the end of their working day. One manager told us the doctors were always friendly and shared relevant detailed information to enable care home staff to provide appropriate support to the resident.

Health, promotion and prevention

The practice offered a broad range of additional services to patients that focused on the promotion of health and disease prevention for example chlamydia screening, insertion and removal of contraceptive implants and NHS health checks.

A range of health promotion leaflets were available to patients. However, it was unclear how patients who required the information in an alternative language could access the information.

We saw evidence to support good results in monitoring outcomes for patients with long term and chronic diseases.

Are services caring?

Summary of findings

The service was caring.

We spoke with patients who told us they were always treated respectfully by the staff who considered their individual needs. This was further evidenced during our observation of staff/patient interactions and discussion with members of staff about the way they provided a service to their patients. However, further improvement was required to ensure that patients with a disability could access the service.

Patients told us they felt involved in decisions about their care and treatment and staff ensured they found answers to any questions they were unable to answer. The surgery had an increasing number of European patients who did not always speak English. We found that staff did not know how to access translation services so that that they could be certain people received information in a form they understood. Moreover, staff could not be sure that they understood the choices and preferences of a patient with limited use of the English language.

Our findings

Respect, dignity, compassion and empathy

We spoke with seven patients who were registered at the practice. All of them told us they were treated with respect by reception staff, the nurses and the GPs. One patient told us that staff made them feel relaxed and at ease and they felt they had a very personal service that took account of their individual needs and wishes. Another patient told us that when the GP could not provide them with an answer straight away, they looked into it and always got back to the patient with an answer.

We saw staff talking with patients at the reception and in the waiting room. Staff were courteous and respected their right to privacy and confidentiality. We saw a notice in the waiting room that informed patients that they could request a chaperone for their appointment if they wanted one. This gave patients additional assurance of their safety during intimate examinations.

One patient we spoke with who had a disability, told us they were unable to visit the practice as they had difficulty with access to the building. However when we looked at the layout of the building, we found there was access for people who could not manage steps or who used a wheelchair. There was no system in place to alert reception staff to help people access the building on their arrival even though the practice had a sign to tell patients they welcomed people who had a disability. We discussed this with the practice manager who agreed to review the arrangements and the information available to patients.

When we met with clinical and non clinical staff, they demonstrated their commitment to providing a patient focused service and this was also evident in the records we reviewed in relation to the management of complaints and business meetings.

The practice had a system in place to ensure that they could identify registered patients who cared for a relative with complex health needs. This ensured that the patient/carer received appropriate support from the practice and their individual circumstances were taken into account. We spoke with a GP who told us the practice always contacted the relatives after a patient died by sending a sympathy card and conducting a home visit if appropriate to do so.

Are services caring?

Involvement in decisions and consent

Patients that we spoke with complimented the care and support they received from the GPs and nursing staff. They told us that they felt involved in decisions about their care and treatment.

The practice had very recently formed a patient participation group (PPG) to represent the views of the registered patients and work with the practice to shape and inform improvements. We noted an information board outside the waiting room that displayed information about the group which had not yet had its first meeting. This included details of their first patient survey, which was in progress, and the rationale used by the group for covering the questions. These included issues such as the appointments booking system, waiting times and privacy at reception.

We noted that there were no signs in the reception area that advised patients they could speak with a member of staff confidentially if they wished to. Practice staff told us that they would accommodate this if a patient asked although this did not happen very frequently.

As the practice had a number of European patients who did not speak English as their first language, we asked what arrangements were in place for interpretation services. Three members of staff, including the practice manager and deputy practice manager, were unaware of interpretation services they could access. One member of staff that we asked did have a contact number for a translation service but acknowledged there was nothing on display in the practice. This meant this group of patients may not have the opportunity to make informed decisions about their care and treatment.

When we asked staff how consent would be obtained from patients who could not speak English, we were told that sometimes family members who could speak English would attend with the patient. Staff also told us about a non English speaking patient who required the use of a short term monitoring kit at home. The practice used “Google Translate” to send them a letter in their first language. However this had not been checked for accuracy and using this facility without first checking the contents could put patients’ safety at risk.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive.

The staff at Springcliffe surgery responded well to individual patients needs and we saw good evidence to support this. However, we found that the practice had not considered the needs of the growing European population in terms of communication and provision of information.

Staff told us that the numbers of registered patients were increasing and this placed more demand on the appointments system. Some patients we spoke with told us they had difficulty accessing an appointment when they needed one. The practice had developed a patient survey which was in progress and included questions about the appointments system and told us this will be used to review current arrangements and plan an appointments system that meets the needs of their population.

The practice had received a low number of complaints about the service. Each one had been considered, investigated and an appropriate response provided. Information about how to complain was available on the practice website but when we spoke with people, they did not know how to complain if they had a need to do so.

Our findings

Responding to and meeting people's needs

The practice provided eight sessions a week by three doctors (two GP partners and a long term locum doctor). This meant there were two afternoons each week (two sessions) when the practice did not have a doctor on the premises. Arrangements were in place to meet a patient's need if they required medical attention the same day. This was provided through a telephone consultation, a home visit, or an urgent appointment at the practice. The practice assured us that patients were seen if they required attention and would not be turned away. This was possible because the practice was linked to another GP practice (registered separately) and shared most of the staff between the two locations. This meant there were sufficient arrangements in place to cover staff absences.

We found that staff responded to patients' individual needs and requests. For example one patient who had a chronic condition, said that staff enabled them to manage their own condition because they received the right level of information to do so. Another patient told us they sometimes felt overwhelmed by the information they received during a consultation. When this happened, they telephoned the practice to ask for clarity about what had been discussed and staff respected this need and were always supportive.

The practice had a growing number of patients who do not speak English as their first language. The practice was not able to demonstrate how they were meeting and responding to the needs of this patient group.

A patient told us they had recently used the out of hours service and their GP had provided support to them the following day. When we spoke with staff we found that patients' electronic records were linked with the out of hours service as well as the local hospice. This meant that records of care were shared between the services and the practice had access to timely information about any care given to their registered patients. The GP's were then able to provide any relevant follow up to the patient.

A patient survey was in progress and the results will be considered by the newly formed patient participation

Are services responsive to people's needs?

(for example, to feedback?)

group. (PPG). It included questions about patient issues such as the appointment booking system, waiting times and privacy at reception and was work in progress. The practice had not completed a survey since 2009.

The practice used the 'Choose and Book' system to enable patient choice about which health provider they wished to attend for further tests or treatment.

Access to the service

Four of the seven patients we spoke with said they had difficulty getting an appointment when they wanted one. For some people, this was because they wished to see the same GP who knew their medical history and personal circumstances. Others felt there were not enough 'on the day' appointments because these were often fully booked shortly after the practice opened in the morning. Two patients told us they were offered telephone consultations if there were no appointments available to them.

All of the staff we spoke with said that the numbers of patients who registered with them had increased in the last two years. New patient's applications were processed and registered on the system; however we were told that new patients were not discussed at practice meetings so that the capacity and demand on the service could be monitored.

Staff told us that the impact of increased patient numbers placed greater demand on the number of appointments that were available for patients. However, staff gave us assurance that patients who required an emergency appointment were seen the same day and at the very least, were provided with a telephone consultation.

We were told that the "Did Not Attend" (DNA) appointment rate was beginning to increase although we did not see any evidence at the practice of how this was being managed to reduce the impact on the availability of appointments. We were told that if a patient had three DNAs in a three month period, they were written to advising of this but there was nothing further in place if it continued to happen.

Concerns and complaints

All of the patients we spoke with told us they had not needed to raise a concern or complaint about the service. Details on how to complain could be found on the practice website. However the practice may find it useful to note that patients were not aware of how to comment on the service or raise a complaint although they said they would ask a member of staff.

Overall there were low numbers of complaints received about the practice. Each complainant received a complaints pack that gave them a good level of information about the procedure. The complaints log demonstrated that there was a clear and systematic method for receiving, responding to and investigating complaints. Letters of response were sent to the complainant when it was relevant to do so and changes were made to improve the service that patients received. An annual complaints summary was completed once a year and we saw that this was shared at the staff meeting.

Are services well-led?

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

Summary of findings

The service was well-led.

There was a structure in place to support leadership and management of the service. Staff told us the team worked well together and that senior staff were approachable although some staff groups did not have the opportunity to engage with the senior team to discuss and contribute to service improvements. Staff received informal support, regular training and an annual appraisal. However, the appraisal system was not always followed in a timely way to ensure that all members of staff had received a current appraisal.

Monthly business meetings involved GPs, nurses and senior administrative staff and addressed a range of quality issues effecting the day to day management of the service. Some clinical and non clinical audits took place but there was no overarching audit plan to engage the team and ensure that quality was being measured, reviewed and improved to benefit patients who used the service. Risk management procedures were in place.

The practice were able to demonstrate that they used feedback from complaints to improve the service. However other methods of feedback had not been developed because their patient group was newly formed and had not had a meeting at the time of our visit.

Our findings

Leadership and culture

The practice manager had delegated authority to make decisions about most non clinical issues that affected the running of the service and had support from the GP partners. Staff at Springcliffe Surgery also worked at another large practice in the city which was run by the same GP partnership and registered separately. The practice manager and assistant practice manager worked at either location each day so that a manager was always present. The practice had plans to review the NHS contracts for both GP practices and believed this would strengthen both services in the future.

All staff we spoke with told us that they had a line manager, they felt supported by the practice and there was a strong teamwork ethic within the practice. Most staff told us that the Practice Manager and GPs were very approachable and they could discuss issues with them, when they were available.

Staff were very patient focused and did their best to ensure that patients who required an appointment were seen in a timely manner.

Governance arrangements

The senior partner was responsible for clinical governance but was not available to talk with us on the day of our visit. Minutes of the business meetings demonstrated that a range of quality issues were reviewed and this included clinical issues.

The practice manager was responsible for monitoring complaints and incidents and the non-clinical aspects of the service. They were not physically present at Springcliffe Surgery each day therefore relied on staff to communicate any issues of concern in a timely way. We also found that the deputy practice manager demonstrated a broad working knowledge of the service and an effective working relationship had been established to support the practice manager.

Documents that we checked identified the person who was responsible for decision making including the authorisation of policy documents.

Are services well-led?

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

Systems to monitor and improve quality and improvement

Effective monthly business meetings were in place which involved senior administrative staff, nurses and GPs. Records of these meetings demonstrated that a range of quality issues were discussed. This included issues affecting registered patient care, feedback from local health meetings in the area as well as national issues such as changes to the notification of reportable disease.

There was no overarching plan for auditing clinical care or support at the practice that engaged all staff in determining the development of services as a whole. Individual doctors completed clinical audits and shared the results at meetings although the reports were not accessible to other members of staff. However, we did review evidence of audits of cleaning services, infection control and health and safety. The results and actions taken demonstrated that improvements were made.

Patient experience and involvement

The practice had recently formed a patient participation group to act on behalf of other patients to provide feedback about their experience and help shape the service. At the time of our visit, the group had not had a meeting so we were unable to see how feedback and involvement in the service was used to make improvements.

Staff engagement and involvement

Practice meetings were held monthly although staff told us they had not been held as frequently since the beginning of 2014. The meetings were attended by the partners, nursing staff and the practice manager/assistant practice manager. Issues were discussed and any learning or areas for development were disseminated to staff. Non-clinical staff were also included in a quarterly staff meeting led by the Assistant Practice Manager that was done on a more informal basis.

The lead nurse told us that nurses meetings varied in frequency although they used to happen on a monthly basis. At the time of our inspection, the nurses provided

more health check appointments and their team had reduced as a nurse had recently left the service. They were looking to reappoint to the role but the increased workload meant that time for meetings was difficult to achieve.

Learning and improvement

Staff were expected to complete online training during designated training time. However we found that they did not all have access to this. The practice told us that staff could claim additional work hours to complete mandatory training but this did not seem to be known by all staff.

We found that staff received regular and relevant training and although some training was due for renewal, we found that these sessions were already booked to take place.

The lead nurse told us that she completed some informal monitoring of the nurses' consultations and the medications administered by them. However, this was not recorded so that learning and improvement could be monitored.

Non clinical staff we spoke with told us that they had a training afternoon once a month where they could either carry out online training or meet to discuss issues.

When we reviewed staff files we saw evidence that an induction process was used for new staff. We also saw records of mediation meetings between staff to resolve conflict.

Identification and management of risk

A health and safety report had been completed in January 2014 and we were shown evidence that demonstrated the actions had been completed. A fire risk assessment was completed annually and had recently been reviewed.

Significant events were managed by the lead GP and discussed at practice meetings. We saw that there was a clear process in place to record the issues, discuss and evaluate any learning that had taken place as a result of each one.

There was a major incident plan in place that had been reviewed by the practice a few weeks before our inspection. The practice manager planned to discuss it at the next staff meeting.

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
Diagnostic and screening procedures	<p>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse.</p> <p>How the regulation was not being met: The provider had not taken reasonable steps to safeguard vulnerable adults from the risk of abuse by ensuring that procedures were in place to identify and respond to potential abuse. Staff had not received the appropriate training to respond to allegations of abuse for vulnerable adults. Regulation 11 (1)(a)(b)</p>
Regulated activity	Regulation
Maternity and midwifery services	<p>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse.</p> <p>How the regulation was not being met: The provider had not taken reasonable steps to safeguard vulnerable adults from the risk of abuse by ensuring that procedures were in place to identify and respond to potential abuse. Staff had not received the appropriate training to respond to allegations of abuse for vulnerable adults. Regulation 11 (1)(a)(b)</p>
Regulated activity	Regulation
Surgical procedures	<p>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse.</p> <p>How the regulation was not being met: The provider had not taken reasonable steps to safeguard vulnerable adults from the risk of abuse by ensuring that</p>

This section is primarily information for the provider

Compliance actions

procedures were in place to identify and respond to potential abuse. Staff had not received the appropriate training to respond to allegations of abuse for vulnerable adults. Regulation 11 (1)(a)(b)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010. Safeguarding people who use services from abuse.

How the regulation was not being met: The provider had not taken reasonable steps to safeguard vulnerable adults from the risk of abuse by ensuring that procedures were in place to identify and respond to potential abuse. Staff had not received the appropriate training to respond to allegations of abuse for vulnerable adults. Regulation 11 (1)(a)(b)