Trent Valley 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.

Ratings

Overall rating for this service	**Inadequate**
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires improvement**
Are services well-led?	**Inadequate**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Trent Valley Surgery on 30 June 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe and well led services. It was also inadequate for providing services for; older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It was rated as 'requires improvement for providing effective services and responsive services. It was good for providing caring services.

Our key findings across all the areas we inspected were as follows:

- Patients were at risk of harm because systems and processes were not in place to keep them safe.
- There were inadequate measures in place to deal with medical emergencies and to enable the practice to function to due foreseeable events such as loss of power, flooding or fire.
- Medicines were not subject to checking by a second person prior to being dispensed. Some medicines were stored in-appropriately.
- Not all staff had received appropriate training to help them recognise suspected abuse in children and vulnerable people and some were unable to demonstrate what action they would take in those circumstances.
- Staff were not clear about reporting incidents, near misses and concerns and there was no evidence of learning and communication with staff.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example we found that the practice did not have a system to ensure nursing staff and GPs routinely

Summary of findings

referred to guidance and guidelines from the National Institute for Health and Care Excellence. There was no effective process to manage safety alerts and disseminate them to staff.

- Patients were positive about their interactions with staff and said they were treated with compassion and dignity. Patient feedback obtained through patient surveys rated the practice very highly.
- Urgent appointments were usually available on the day they were requested.
- Patient records held in paper format were not stored securely so as to prevent unauthorised access.
- The practice had ineffective leadership and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure that systems are in place to ensure the continued suitability of staff to work in a healthcare environment.
- Ensure staff receive training to ensure they can deliver safe and effective healthcare.
- Ensure that incidents, near misses and complaints are recorded correctly, investigated and any learning cascaded to staff.
- Ensure that suitable equipment and plans are in place to enable staff to deal with medical emergencies.
- Have an effective business continuity plan to deal and foreseeable events that may prevent the practice functioning normally.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Introduce an appropriate system to ensure medicines are dispensed safely.
- Ensure that there are the appropriate procedures in place to ensure the safe storage of medicines.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that all staff are covered by an appropriate level of professional indemnity insurance.
- Establish a clear leadership structure with the capacity and support to ensure that improvements to the service can be delivered.
- Patient records stored in paper format should be stored securely so as to prevent unauthorised access and to mitigate the risks associated with such events such as fire.
- Ensure the provider CQC Registration is brought up to date.

The areas where the provider should make improvement are:

- Establish a Patient Participation Group
- Update their practice information leaflet to reflect changes in out-of-hours arrangements.

On the basis of the ratings given to this practice at this inspection, I am placing the provider into special measures. This will be for a period of six months. We will inspect the practice again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made. Staff were not clear about reporting incidents, near misses and concerns. Although the practice carried out some investigations when things went wrong, they were not thorough and lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were not in place or were not implemented in a way to keep them safe. For example, recruitment procedures were insufficient, there was no process to ensure the suitability of staff and staff had not received the appropriate training. Medicine management was lacking. Arrangements for dealing with medical emergencies and the management of foreseeable events that may cause the practice to cease functioning were inadequate.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at the average for the locality. Knowledge of and reference to national guidelines were inconsistent. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent. Staff had not received training appropriate to their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Patients rated the practice very highly when it came to making an appointment with a GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available. However, there was no evidence that complaints had been properly investigated or that learning had been shared with staff.

Summary of findings

Are services well-led?

Inadequate 

The practice is rated as inadequate for being well-led. The practice had a number of policies and procedures to govern activity, but many were not adhered to and some staff did not know of their existence or contents. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings and not recorded. The practice had not proactively sought feedback from staff and did not have a patient participation group (PPG). Staff told us they had received annual appraisal but no member of staff we spoke with had received any supervision of their practice or performance review. Staff did not have appropriate professional indemnity insurance. The CQC registration did not accurately reflect the true position at the practice. The practice had identified many of these issues prior to our inspection and had produced an action plan to address them.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate 

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive . The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs

People with long term conditions

Inadequate 

The practice is rated as inadequate for the care of people with long term conditions. The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. However, not all these patients had a named GP, a personalised care plan or structured annual review to check that their health and care needs were being met.

Families, children and young people

Inadequate 

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working age people (including those recently retired). The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had 32 patients on the learning disability register. Most of these patients were in a large residential care home and the practice conducted weekly 'ward round' type visits to meet these patients' needs.

To ensure reception staff were aware a board behind the reception desk, that was visible to staff only, detailed those patients who were considered vulnerable.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Most staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

The provider was rated as inadequate for safety and for well-led and requires improvement for effective and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

93.5% of people experiencing dementia had received an annual medication review. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete. We received 45 completed comment cards and all were positive about the care and treatment provided. Patients felt staff had a caring nature and treated them with respect and dignity.

We spoke with three patients who used the service. They told us they got an appointment when they wanted one, often on the day, were treated with dignity and respect and knew how to make a complaint. Two told us they had been referred to secondary care which was dealt with efficiently and expeditiously.

All of the comments cards expressed positive views on the standard of care, quality of staff and the excellence of the doctors. The said the premises were clean and tidy and commented upon the availability of same day appointments. They said staff were fully involved and were responsive to patient needs.

This feedback was aligned with the national GP patient survey results which included feedback from 122 patients. For example, 97% respondents said they found it easy to get through on the telephone, 98% said their experience of getting an appointment was good and 91% of respondents with a preferred GP said they usually got to see or speak to that GP. All of these results were significantly higher than CCG and national averages.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure that systems are in place to ensure the continued suitability of staff to work in a healthcare environment.
- Ensure all clinical staff have appropriate professional indemnity.
- Ensure staff receive training to ensure they can deliver safe and effective healthcare.
- Ensure that incidents, near misses and complaints are recorded correctly, investigated and any learning cascaded to staff.
- Ensure that suitable equipment and plans were in place to enable staff to deal with medical emergencies and foreseeable events that prevented the practice functioning normally.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure that there are the appropriate procedures in place to ensure the safe storage of medicines.
- Introduce an appropriate system to ensure medicines are dispensed safely.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that all staff are covered by an appropriate level of professional indemnity insurance.
- Establish a clear leadership structure with the capacity and support to ensure that improvements to the service can be delivered.
- Ensure the provider CQC Registration is brought up to date.
- Patient records stored in paper format should be stored securely so as to prevent unauthorised access and to mitigate the risks associated with events such as fire.

Action the service SHOULD take to improve

- Establish a Patient Participation Group
- Update their practice information leaflet to reflect changes in out-of-hours arrangements.

Trent Valley Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP specialist advisor and a Practice Manager specialist advisor.

Background to Trent Valley Surgery

Trent Valley Surgery provides primary medical services to 4,148 patients from two sites, the primary site being at 85 Sykes Lane, Saxilby and a branch site at Main Street, Torksey. Both locations were visited during the course of our inspection. Both locations have a dispensary which dispense to 2,499 (60%) eligible patients.

The practice serves a rural community and the Sykes Lane location shares the premises with another practice, The Glebe Practice.

The practice has two partner GPs, a nurse practitioner, a nurse and a phlebotomist. They are supported by a temporary practice manager, reception and administrative staff.

The practice is registered incorrectly with the Care Quality Commission. It is registered as an individual, when in effect it is a partnership with two GP partners.

The practice has high percentage of older patients, notably aged between 65 and 75 and a lower percentage of patients under the age of 18 when compared nationally.

The practice is located in an area of low deprivation. The practice has a high percentage of patients with long term health conditions and with caring responsibilities when compared nationally.

The practice holds a General Medical Services (GMS) contract for the delivery of general medical services..

The service is commissioned by Lincolnshire West Clinical Commissioning Group.

The Sykes Lane surgery is open between 8am and 6.30pm Monday to Friday and the Torksey surgery from 10.30am to 2.30pm GP consultations are available from 8.30 am to 6pm. Appointments with nurses and phlebotomists were available from 8.10am.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. Out- of- Hours services are provided through Lincolnshire Out-of-Hours Service which is provided by Lincolnshire Community Health Services NHS Trust. Patients access the service via NHS 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

Detailed findings

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 30 June 2015. During our visit we spoke with a range of staff including the temporary practice manager, two GPs, two nurses, dispensers, reception and administration staff. We spoke with three patients who used the service. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not have processes in place to prioritise safety, identify risks and improve patient safety. For example, reported incidents and national patient safety alerts, as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents but did not know of the need to report near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the last year and saw that although the incidents had been reviewed there was no evidence that any learning had been shared with staff, including the member of staff involved in the incident. We looked at the minutes of the four practice meetings held in 2014 and the one meeting held in 2015. Significant events had not been discussed and were not a standing item on the practice meeting agenda. There were no dedicated meetings to review actions from past significant events and complaints. There was no evidence that the practice had learned from these or that the findings were shared with relevant staff.

Although there was a protocol in place for handling National patient safety alerts which had been reviewed in October 2015, the protocol was not being adhered to. The protocol stated that all staff were to be emailed with the alert and then it would be filed and discussed at the next meeting. No member of staff we spoke with could recall seeing an alert recently. Alerts were not discussed at meetings.

Reliable safety systems and processes including safeguarding

The practice did not have effective systems to manage and review risks to vulnerable children, young people and adults. The practice policy stated that all staff would be trained in child safeguarding every two years and within six months of starting work at the practice. We looked at training records which showed that not all staff had received relevant role specific training on safeguarding. For example we saw that two members of the clinical staff who came into direct contact with patients had not received any training. The two members of staff had worked at the practice for nine and 12 years respectively. Some other staff such as dispensers and receptionists had also not received any training. We spoke with two members of staff who knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. However we spoke with another long serving member of staff who was unable to explain to us what safeguarding was, although they said they had seen the signs within the surgeries about it.

The senior GP partner was the lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. Some members of staff we spoke with were aware of who to speak with in the practice if they had a safeguarding concern, however two members of staff did not know who the lead was nor what action they should take if they had a concern.

Staff we spoke with told us there was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority, although there was no evidence, such as records of meetings, to support that premise.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice was unable to demonstrate that any member of staff had received any chaperone training. Reception staff would act as a chaperone if nursing staff were not available and although they had not received any training those we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. With the exception of one, the practice was unable to demonstrate that staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have

contact with children or adults who may be vulnerable). The practice policy on chaperoning stated that non-clinical staff engaged in chaperoning would not have a DBS check but a risk assessment would be undertaken. No such risk assessment could be produced for any member of staff.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed that fridge temperature checks were carried out on the vaccine fridge at Saxilby by means of a data logger which was downloaded onto the computer approximately every six weeks. However there was no system in place to ensure that fridge temperatures were checked on a daily basis to ensure that vaccines had been stored within the prescribed temperature range, so ensuring their efficacy.

At the Torksey surgery we saw that drugs requiring refrigeration, were stored in a domestic refrigerator along with staff foodstuffs. There was no thermometer and the internal wire racking was corroded and discoloured.

Processes were in place to check medicines were within their expiry date. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of appropriately.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times

There was a system in place for the management of high risk medicines such as methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs.

A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Standard operating procedures had been recently reviewed and updated. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed by a GP. However we spoke with one dispenser who said they had completed their training in 2006 and they thought they would benefit from refresher training.

There was no positive culture in the practice for reporting and learning from medicines incidents and errors. For example we were made aware of an incident that related to GP prescribing ten times the amount of ferrous sulphate as was intended. The mistake was spotted by the dispenser, who referred to the GP and the mistake was rectified. This incident had not been logged or reviewed promptly to help make sure appropriate actions were taken to minimise the chance of similar errors occurring again. It had not been recorded as an incident or near miss. We also reviewed a significant event when controlled drugs were dispensed in excess of that prescribed. The review of the event had been dealt with by the senior GP partner, practice manager and dispensary manager. The action required as a result of the review was that all medicines should be checked by two people before being dispensed. We spoke with two dispensers who told us they worked isolation at the two dispensaries and there was no checking of medicines prior to being dispensed. One of these staff was the dispensary manager.

Inadequate

Are services safe?

Cleanliness and infection control

We observed the premises to be very clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. The lead for infection prevention and control was named as the practice manager who had left 14 months prior to the inspection. A nurse had been nominated to take on the role.

There was no evidence that any member of staff had received any training in infection prevention and control other that the temporary practice manager. We saw evidence that the practice had commissioned a company to undertake an infection prevention and control audit of both sites and that had been completed the day prior to our inspection. The last recorded previous audit was in November 2012.

Notices about hand hygiene techniques were displayed at hand washing sinks with hand gel and hand towel dispensers available in treatment rooms as well as staff and patient toilets.

The practice had commissioned a risk assessment for legionella and an under-performing hot water boiler had been identified as a medium risk. The water system was shared between the three occupants of the building and we saw that a meeting had taken place with the landlords to discuss the replacement of the faulty equipment.

There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was July 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices .

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However the records we looked showed that the policy had not been followed and that appropriate recruitment checks had not been undertaken prior to employment. For example it stated that staff would not commence work until two satisfactory references had been received and that DBS disclosure documents sought and received. Further is stated that DBS checks for clinical staff would be renewed every three years of more frequently if deemed necessary. We looked at the staff files of two nurses, phlebotomist a receptionist and two dispensers. The files of the two nurses contained no proof of identification, references, qualifications or evidence of the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The files of the phlebotomist and other non-clinical staff were similarly deficient in several respects. We asked the practice manager if there were any other documents or evidence that recruitment procedures had been undertaken correctly. They said there were not. The practice was unable to show any evidence that, with the exception of a receptionist, that any member of staff had been subject to a DBS disclosure.

We looked at the information that the practice held on a locum GP who worked regularly at the practice. The only information held on the GP was evidence of their re-validation, inclusion on the performers list and evidence of professional indemnity insurance.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There were enough staff to keep people safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

to the practice. These included regular checks of the building, the environment, staffing, and equipment. The practice also had a health and safety policy. However we found that staff were not always aware of these policies.

Arrangements to deal with emergencies and major incidents

The practice did not have in place arrangements in place to manage emergencies. All staff had not received training in basic life support. No oxygen was available at either surgery for use in a medical emergency. The senior GP partner told us they had never used it in 13 years and as a result they considered it to be an acceptable risk not to have oxygen. There had been no risk assessment undertaken. The practice manager told us there was an agreement with the neighbouring practice to use their oxygen but no process was in place to ensure it was regularly checked and available. When we asked members of staff, including nurses how they would access oxygen if required, none was able to tell us that they would go next door to the neighbouring practice.

Emergency medicines were easily accessible to staff in a secure area of the practice and clinical staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, flooding and access to the building. The document was deficient in not providing the contact details of key stake holders in the case of emergency.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, however the senior GP partner told us that accessing National Institute for Health and Care Excellence (NICE) guidance was a matter for the individual clinician and there was no means of sharing guidance throughout the practice.

Minutes of the practice meetings held in 2014 and 2015 showed that NICE guidance had not been discussed.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, for example one nurse was the lead for chronic obstructive pulmonary disease which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support, however the staff we spoke with told us that no clinical supervision process took place.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that the practice kept a visual reference to show which patients were in or were discharged from hospital to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients.

The practice showed us four clinical audits that had been undertaken in the last two years. The GPs told us clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding cholesterol management in diabetic patients. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. We also saw how the practice had conducted an audit regarding oral nutritional supplements and how changes they had made a result had achieved substantial cost savings.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. It achieved 94.8% of the total QOF target in 2014, which was above the national average of 93.5%. Specific examples to demonstrate this included:

- The percentage of patients with hypertension having regular blood pressure tests was 11.2% above the national average
- Clinical exception rate was better, at 1.4% below the national average.
- For patients suffering heart failure the practice performance was 8.9% above the CCG Average and 2.9% above the England average.

However we also saw that;

Requires improvement

Are services effective?

(for example, treatment is effective)

- In caring for patients suffering from poor mental health the practice performance was 12.1% below the CCG average and 10.1% below the England average.
- In caring for patients with dementia the practice performance was 9.1% below the CCG average and 13.2% below the England average.
- In caring for patients with depression the practice performance was 8.7 % below the CCG average, and 4.7% below the England average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and the GPs told us how they intended to address them.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had multidisciplinary meetings every two months to discuss the care and support needs of patients and their families, however as the district nurses were housed in the same building as the practice they also had a good informal working relationship that was of benefit to patients in palliative care.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with a learning disability. Structured annual reviews were also undertaken for people with long term conditions. For example 90.1% of patients with diabetes and 91.8% of patients with COPD had an annual medication review.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data such as prescribing from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that the only training that had been recorded since April 2013 was cardiopulmonary resuscitation, fire safety and customer service. Nurses had completed training in cytology in June 2011 and immunisations and vaccinations in 2014 and 2015. We noted that the practice had identified that training was not up to date and provided us with some evidence that they had taken steps to rectify the situation by providing on-line training for staff. They were able to show us that training for clinical staff in safeguarding vulnerable adults and children had been arranged with an outside provider.

Both GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff and records we saw confirmed that little in the way of training or courses had been provided.

There was no evidence that the practice was making use of clinical supervision and staff meetings to assess the performance of clinical staff.

Practice nurses were able to provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example chronic obstructive pulmonary disease, were not able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with

complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports, pathology results were all seen and actioned by a GP on the day they were received. Incoming mail consisting of discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively in line with national averages.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. Some of the staff from other health care providers who attended these meetings were housed in the same building as the practice and staff told us that fostered a good working relationship. Staff told us these meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning although no records or written minutes of the meetings were kept.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff had received no training or instruction in the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. The nurse we spoke with was unaware of the provisions of the key parts of the legislation although they did have folder containing some information about it.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Clinical staff we spoke with demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 8.6% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. 3.1 % are recoded as having stopped smoking in the year to the end of March 2015.

Requires improvement

Are services effective?

(for example, treatment is effective)

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 82.13%, which was above the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered flu vaccinations in line with current national guidance. Last year's performance was below average. For example:

- Flu vaccination rates for the over 65s were 42.71%, and at risk groups 65.36%. These were below the national averages of 52.29% and 73.24% respectively.
- We saw the data that related to childhood immunisation rates was comparable to other practices in the area. There was no data available that would enable us to compare those figures with the average for the clinical commission group.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey of 2014.

The evidence from this survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 96% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 96% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 99% said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

The practice was rated 110 out of the 7,952 practices across England in the GP Patient Survey and was the highest rated GP surgery in Lincolnshire.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 45 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Signs were displayed at the reception desk and dispensary reminding patients that a room was available for private discussions to take place.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that an aide memoire was attached to the reception desk to remind staff of the protocols on sharing patient information.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them in the past diffuse potentially difficult situations but its use was very rare.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice highly in these areas. For example:

- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 96% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 99% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

A GP told us that support in the case of bereavement was variable as some deceased had few if any known relatives. They told us that the there was a bereavement support group based in the village who they referred to and a bereavement councillor was available through a funeral director.

We spoke with one nurse who didn't know of any bereavement service that the practice did, nor anything special for carers. They stated that if they found out that someone was a carer for an elderly person they would give them the Age Concern as she was aware that they would advise on subjects such as attendance allowance.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient survey. These had included locating a dispenser at the branch surgery at Torksey (which had been implemented) and improving telephone access for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the practice had a large residential care home with over 100 residents who were patients of the practice. Many of these patients had complex needs including mental health issues and learning disability. The practice had 32 patients on the learning disability register.

The overwhelming majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. One receptionist we spoke with didn't know that a translation service was available.

The premises and services had been designed to meet the needs of people with disabilities. Both surgeries were accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services.

There was a system for flagging vulnerability in individual patient records.

The reception area had a board out of sight of patients that showed recent births, deaths, palliative and vulnerable patients and very elderly or poorly so that staff were kept informed.

Both GP partners were male. Patients were unable to exercise a choice of consulting with a female GP.

There was a policy relating to Equality and Diversity but there was no evidence that the practice provided equality and diversity training. Staff we spoke with confirmed that they had not had any such training or discussion but asserted that all patients were treated equally on the basis of need.

Access to the service

The Sykes Lane surgery was open between 8am and 6.30pm Monday to Friday and the Torksey surgery from 10.30am to 2.30pm GP consultations are available from 8.30 am to 6pm. Appointments with nurses and phlebotomists were available from 8.10am. Currently there was no weekend opening, but with the demographic of the practice this wasn't considered a concern. We were told that extended opening had been trialled but didn't have a high uptake. One third of appointments were pre-bookable the remainder being available on the day.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes. The practice carried out a regular 'ward round' to one home with over 100 residents who were patients of the practice, on one day a week.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Longer double appointments for patients were available for those with more complex needs or if a procedure required them.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 90% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 98% described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 93% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.
- 98% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice, which was the practice manager.

We saw that information was available to help patients understand the complaints system by means of posters displayed in the reception areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had needed to make a complaint about the practice.

We looked at the six complaints that had been recorded since October 2014 and found that the only action noted was in respect of one complaint and stated 'will speak to dispensary staff'. This was for a complaint in March 2015. When we asked the dispensing staff on duty they did not know of the complaint.

No complaints were discussed in practice meetings and were not an agenda item. Complaints were not discussed with staff. There were no annual reviews or analysis of complaints to identify trends.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients, which was shared by all of the staff we spoke with. However we did not see any evidence that the practice had any strategy for the future and to ensure as far as was possible that the service continued to operate.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in hardcopy form only. They were not currently available to staff to view on the practice computers. We looked at nine of these policies and procedures and saw that all had been reviewed recently and were up to date. There was no process in place for identifying which members of staff had acknowledged reading the policies.

We asked to view the professional indemnity insurance for GPs and other practice staff including nurses and the phlebotomist (professional indemnity insurance covers legal costs and expenses incurred in the defence, as well as any costs that may be awarded, if a member of staff is alleged to have provided inadequate advice, treatment or care.) We were told that there was no practice policy and that GPs provided their own cover. The practice manager told us that to the best of their knowledge no other member of staff had any such indemnity cover and that as far as they knew there was no policy in place.

The practice had suffered some disruption as result of the long standing practice manger having retired in September 2014 and the replacement manager having left four weeks prior to our inspection. An interim practice manager was in place working three days weekly. (Since our inspection we have been informed that this person has now been appointed as the full time practice manager) As a result of the upheaval some aspects of the leadership structure and responsibilities were blurred. However when we spoke with members of staff and they were all clear about their own roles and responsibilities.

The practice used the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. However there had been only one practice meeting in 2015 and QOF data was not discussed. There were no action plans produced to maintain or improve outcomes. GPs told us there were six monthly meetings to discuss QOF but no records or notes of the meetings were kept.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw that audits had been completed diabetes cholesterol management and oral nutritional supplements. They had been repeated to complete the full audit cycle.

There were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients. The practice regularly submitted performance data to the CCG.

The practice did not hold regular staff meetings where governance issues were discussed. We looked at minutes from the only meeting held in 2015. Items discussed were the forthcoming CQC inspection, the need to undertake training and the transfer of patients to new blood glucose monitoring strips. There was no record that performance, quality and risks had been discussed. Four meetings had been held in 2014. No significant events had been discussed.

We reviewed a number of policies, for example equality and diversity which were in place to support staff. The policies were not available on the practice computer system and staff had to rely on paper copies that were held at both surgeries. We were told that it was planned to have them available on the practice computer system. The practice had a whistleblowing policy which was also available to all staff in the staff handbook. We saw laminated posters were in place to inform staff of the correct whistleblowing procedures, although we spoke to one member of staff who could not tell us what whistleblowing was, although they said they had seen the poster.

Patent records stored in paper format, commonly known as Lloyd George records, were stored on open shelving at both surgeries, behind the reception area. There was no shuttering or doors to secure the records within the shelves. Although they were not accessible to members of

Are services well-led?

Inadequate

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

the public or patients, they were accessible to people such as cleaning staff or outside contractors or undertaking work. There was no risk assessment in place to mitigate the risks to the information from unauthorised access or loss or damage through fire or flood.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. Staff we spoke with said they were encouraged to express their ideas and views about how the service could be improved.

Practice meetings were held irregularly, there being only one in 2015 so opportunities for staff to raise any issues at team meetings were limited. One GP told us that any discussing or learning was not shared with all staff but only with those concerned. They gave an example that they wouldn't share a clinical issue with an administrative team member.

Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice did not have a patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice manager told us that it was planned to form a PPG as soon as practicable.

The practice had reviewed its' results from the national GP survey,(in which it had achieved very high satisfaction levels), to see if there were any areas that needed addressing. The practice had reacted to the survey by locating a dispenser at the Torksey surgery and was actively reviewing its telephony system to provide better functionality.

The practice had no formal mechanism to gather feedback from staff although staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

No attempt had been made to actively learn from complaints. They were not discussed in practice meetings and they were not an agenda item. Complaints were not discussed with staff. There were no annual reviews or trends identified.

Management lead through learning and improvement

We looked at five staff files and saw that regular appraisals took place which included a personal development plan.

Staff told us that the practice supported them to maintain their clinical professional development but we saw that very little was documented. For example the practice nurses had received training in cervical cytology and immunisations and vaccinations and one of those nurses had received training in asthma in 2011 and in contraception, bronchiectasis and travel health in 2010. Staff had not received the training required to support them in meeting patient needs. For example there was no evidence that any member of staff had received training in infection prevention and control other than the practice manager.

The practice had not shared with staff completed reviews of significant events and other incidents to ensure the practice improved outcomes for patients.