

Dr Lisa Terrill & Partners

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		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Requires improvement	
Are services well-led?		Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Terrill & Partners (Collingham Medical Practice) on 28 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and well-led services. It was also good 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) and people whose circumstances may make them vulnerable.

It required improvement for providing responsive services and care for people experiencing poor mental health.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Urgent appointments were usually available on the day they were requested. However, patients said they sometimes had to wait a long time for non-urgent appointments and that it was very difficult to get through the practice when phoning to make an appointment.
- Information about how to complain was not easily available for people who used the service.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with improvements required to storage of clinical waste.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and most staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

The practice coordinated the provision of a volunteer led transport service with the patient participation group (PPG). The service is for patients registered with the practice who struggle to access public transport within the village. A team of volunteer drivers used their own cars to support patients to attend a range of health related appointments and social activities. At the time of our inspection there were 18 drivers, 250 registered patients and 256 trips had been undertaken to hospitals and the GP practice.

This feature was outstanding in that service provision went beyond the normal scope of clinical practice and the practice used additional resources available to them to ensure patients within the rural community were supported to access health services and community activities.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider must:

- Ensure the regular review of phone access, processes for making appointments and availability of non-urgent appointments; as part of assessing, monitoring and improving the quality and safety of services.
- Ensure information and guidance about how to complain is available and accessible to everyone who uses the service. Additionally, effective systems must be in place to ensure that all complaints are investigated without delay and verbal complaints are fully recorded.

In addition the provider should:

- Ensure completed clinical audit cycles are undertaken and used to drive improvements.
- Ensure infection prevention and control processes are reviewed and strengthened, specifically the storage of non-clinical waste.

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?

The practice is rated as good for providing safe services.

Information about safety was recorded, monitored, appropriately reviewed and addressed. This included a comprehensive system for reporting and managing significant events. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to ensure patient safety and support improvement.

Risks to patients were assessed and well managed to keep patients safe. This included arrangements for safeguarding of children and vulnerable adults, recruitment, medicines management, and dealing with emergencies. Improvements had been made to ensure there were enough staff to keep patients safe. Infection control practices needed to be strengthened, specifically clinical waste storage.

Good



Are services effective?

The practice is rated as good for providing effective services.

Systems were in place to ensure that clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Structured annual reviews were undertaken to check that patients' health and care needs were being met.

Staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multi-disciplinary teams to ensure the effective coordination of patient information and integrated care.

Data showed most patient outcomes were comparable and some were slightly below the locality average. However, there was limited evidence of completed clinical audit cycles (other than medicines management) or to demonstrate that audits were driving improvement in performance and patient outcomes.

Good



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

National patient survey data showed that most patients rated the practice in line with others for several aspects of care. For example, 88% of respondents said the last GP they saw or spoke to was good at treating them with care and concern compared the local average of 84% and national average of 85%.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Care planning arrangements needed to be strengthened specifically for people experiencing poor mental health needs to ensure they were personalised and contained concise information regarding their care. Information for patients and support services available was easy to understand and accessible. This included carer information and details of specific support groups.

Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services.

The practice reviewed the needs of its local population and provided a range of in-house services to ensure patients could access services closer to home. The practice had good facilities and was well equipped to treat patients and meet their needs.

An outstanding feature we noted was the provision of a volunteer transport service coordinated by the practice and the patient participation group. A team of volunteer drivers used their own cars to support patients attend a range of health related appointments and social. This enabled patients to retain their independence and to access community services.

Feedback from patients and data reviewed showed improvements were required to phone access and appointment availability. For example 64% of respondents to the national patient survey described their experience of making an appointment as good compared to a local average of 71% and national average of 73%.

reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. We found the practice had made recent changes to address this but systems were not fully embedded.

Most of the complaints reviewed showed the practice responded appropriately to issues raised. Learning from complaints was shared with staff and other stakeholders to improve patient care.

Requires improvement



Summary of findings

However, verbal complaints were not always recorded in detail and information about how to complain was not easily accessible to patients to ensure they fully understood how to progress concerns and complaints This did not ensure they fully understand how to progress concerns and complaints.

Are services well-led?

The practice is rated as good for being well-led.

The practice had a clear vision and strategy to promote good outcomes for patients. The strategy to deliver this vision had been reviewed and discussed with staff. Staff were clear about the vision and their responsibilities in relation to this. They told us patients were at the centre of everything they did. There was a clear leadership structure and most staff felt supported by management.

The practice had a number of policies and procedures to govern activity and regular governance meetings were held to review the service provision. There were systems in place to monitor and improve quality and identify risk. Formal meetings were held to support shared learning and to drive improvements. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was actively involved in the review of services.

Good



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

The practice is rated as good for the care of older people.

Patients over the age of 75 years had a named GP. The practice offered proactive care to meet the needs of the older people in its population. This included nurse led reviews for patients who were housebound, same day appointments / telephone contact and a range of enhanced services, for example, in dementia and end of life care.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Patients were offered a structured annual review to check that their health and medication needs were being met. A range of in-house services such as phlebotomy and spirometry was offered.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Longer appointments and home visits were available when needed. Improvements were required to the phone access and the appointment system to ensure better experience for patients.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

There were systems in place to identify and follow up children living in disadvantaged circumstances and those at risk of abuse or deteriorating health conditions. Appointments were prioritised and available outside of school hours.

The premises were suitable for children and babies. Mothers had access to pregnancy and post-natal care and young people had access to contraception advice.

The child health clinic was open on alternate weeks on Wednesdays between 1pm and 3pm. We saw good examples of joint working with midwives, health visitors and community nursery nurses. Immunisation rates were relatively high for all standard childhood immunisations.

Good



Summary of findings

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

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 and flexible. This included offering online services for appointments and prescriptions as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients with a learning disability. They were offered an annual health check and longer appointments; and care plans were in place where appropriate. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and students with autism, learning difficulties or challenging behaviour living a local residential school.

Two of the GP partners were trained and accredited with Lincolnshire Social Services to undertake health assessments for looked after children. The practice identified patients who were also carers and offered additional health checks and advice. Information about support groups and voluntary organisations was available in the waiting room.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

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

People experiencing poor mental health were offered an annual physical health check. Dementia screening was offered to patients identified in the at risk groups. Arrangements for care planning for patients experiencing poor mental health and / or dementia required improvements.

Good



Summary of findings

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards which reflected mixed views on the practice. Three cards contained positive comments, five contained mixed views and three contained less positive feedback about the standard of care received.

Positive comments related to staff being helpful and caring; and dealing with patients in an efficient and friendly manner. Less positive comments related to: poor phone access, “long” waiting times for calls to be answered by staff, waiting times of up to five weeks to access routine appointments, limited availability of male doctors and continuity of care not being maintained. The less positive comments were aligned to patient feedback we received on the day of the inspection.

We spoke with 12 patients during our inspection, including two members of the patient participation group (PPG). Most patients said they were happy with the care they received, and felt staff were professional, approachable, and caring. They said staff listened to them and information about their health care needs was clearly conveyed to ensure they were involved in decisions about their care.

This was also reflected in the practice’s own survey results. For example; 96% said the GP was good at putting them at ease, 95% said they were involved in decisions about their care and 100% said they were happy to see the same GP again.

The national GP patient survey results published on July 2015 showed the practice was mostly performing in line with local and national averages. There were 250 surveys sent out and 131 responses received which represented 52%.

The practice did best in the following areas:

- 96% said the last nurse they saw or spoke to was good at listening to them compared with a CCG average of 92% and a national average of 91%.
- 95% said the last nurse they saw or spoke to was good at treating them with care and concern compared with a CCG average of 91% and a national average of 90%.
- 91% find the receptionists at this surgery helpful compared with a CCG average of 84% and a national average of 87%.

Areas the practice could improve included:

- 33% of patients with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62% and a national average of 60%.
- 64% describe their experience of making an appointment as good compared with a CCG average of 71% and a national average of 73%.

70% of respondents would recommend this surgery to someone new to the area compared with a CCG average of 77% and a national average of 78%.

Areas for improvement

Action the service **MUST** take to improve

- Review the systems for assessing and monitoring the quality and safety of service provision regularly to ensure risks are managed appropriately. Specifically, improving phone access, processes for making appointments and availability of non-urgent appointments.
- Ensure information and guidance about how to complain is available and accessible to everyone who

uses the service. Additionally, effective systems must be in place to ensure that all complaints are investigated without delay and verbal complaints are fully recorded.

Action the service **SHOULD** take to improve

- Ensure completed clinical audit cycles are undertaken and used to drive improvements.

Summary of findings

- Ensure infection prevention and control processes are reviewed and strengthened, specifically the storage of non-clinical waste.

Outstanding practice

The practice coordinated the provision of a volunteer led transport service with the patient participation group (PPG). The service is for patients registered with the practice who struggle to access public transport within the village. A team of volunteer drivers used their own cars to support patients to attend a range of health related appointments and social activities. At the time of our inspection there were 18 drivers, 250 registered patients and 256 trips had been undertaken to hospitals and the GP practice.

This feature was outstanding in that service provision went beyond the normal scope of clinical practice and the practice used additional resources available to them to ensure patients within the rural community were supported to access health services and community activities

Dr Lisa Terrill & Partners

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 GP, a second Inspector, pharmacist inspection manager, a practice nurse and an expert by experience.

Background to Dr Lisa Terrill & Partners

Dr Lisa Terrill & Partners provides primary medical care services to approximately 6 850 patients; within 31 surrounding villages covering an area of 132 square miles. The practice is also known as Collingham Medical Centre and is located in the rural village of Collingham.

The practice has a Primary Medical Services (PMS) contract with NHS England. This is a contract supporting the practice to deliver primary care services specifically tailored to the local community or communities additional to those provided under the General Medical Services (GMS) contract.

There are currently two GP partners and three salaried GPs. Each of the GPs provides six sessions each week which equates to a total of 3.75 working time equivalent. With the exception of one male GP, all other clinical staff is female. The practice is a teaching practice which means GPs in training also see patients. At the time of our inspection there were no GPs in training.

The GPs are supported by a team of seven nursing staff. This includes three practice nurses, two health care assistants and two phlebotomists all working a variety of hours.

Collingham Medical Centre is a dispensing practice and dispenses medicines to patients who live more than 1.6 km from a pharmacy. The dispensing of medicines is co-located with a community pharmacy. There are two separate dispensaries but with one collection point. A pharmacist manages the dispensary service and two dispensary staff are employed.

The administration and reception team comprises of 14 staff members and they are led by the practice manager, who is also one of the practice partners.

The surgery is open to make appointments by telephone between 8.15am and 6.30pm on Mondays and 8.15 am to 6.30pm Tuesdays to Fridays. Online bookings are also available, if preferred. Patients requiring a GP outside of normal working hours are advised to contact the practice and they will be directed to the out of hours service. This is provided by Central Nottinghamshire Clinical Services (CNCS).

Community staff employed by the local NHS Trusts are also based at the Collingham medical centre and this includes the community nurse, health visitor, midwife and community nursery nurse. Appointments are also available to see a clinical psychologist, counsellor, physiotherapist, audiologist and chiropodist at the practice.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of 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, and to provide a rating for the service under the Care Act 2014.

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

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 inspecting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. This included feedback received from patients before the inspection, Healthwatch, NHS England and the Clinical Commissioning Group.

We carried out an announced inspection on 28 July 2015. During our inspection we spoke with a range of staff (GPs, practice nurses, reception staff and the health visitor) and spoke with 12 patients who used the service. We observed how people were being cared for and reviewed a sample of treatment records of patients. We reviewed 11 comment cards where patients shared their views and experiences of the service. We also received written statement from the local Councillor following our inspection.

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. This included significant events, reported incidents, national patient safety alerts, patient concerns as well as near misses. Staff we spoke with confirmed they were actively encouraged to report safety issues and some staff attended the monthly meetings where significant events and vulnerable patients were discussed.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the past 15 months. These showed an open and transparent approach in reporting and recording significant events. The practice had comprehensive criteria for identifying significant events; including events related to chronic disease management, any deaths or cancer diagnosis, concerns related to acute care as well as the administration of the practice.

Meeting minutes showed clear evidence of actions taken to improve safety within the practice. Lessons learnt were discussed and reviewed to promote shared learning among staff; and to prevent similar incidents happening again. For example a patient's urine samples were being sent to the laboratory in wrong bottles and the recent results had not been filed the day it was received within the practice. Actions were agreed to prevent this from happening and contact was made with patient's daughter to inform them of the errors and offer an apology.

The practice had appropriate systems and processes in place to keep people safe. This included:

Suitable arrangements for safeguarding vulnerable adults and children from abuse

The practice had a safeguarding policy in place which reflected relevant legislation and local requirements; although the adult safeguarding policy was due for review in 2014. Staff demonstrated awareness of their responsibilities to identify and respond appropriately when abuse was suspected or had occurred. Training records showed the majority of staff had received relevant role specific training on safeguarding and one of the GP partners was the lead for safeguarding.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to

vulnerable adults, children and young people who were looked after or on child protection plans were clearly flagged and reviewed. Staff were proactive in monitoring children and vulnerable adults who attended accident and emergency (A&E) or missed their health appointments frequently. The health visitor we spoke with confirmed positive working relationships with the GPs, nurses and midwife in respect of addressing any safeguarding concerns raised.

Chaperones

A notice was displayed at the reception desk advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). 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.

Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, kept patients safe. This covered areas such as obtaining, prescribing, recording, handling, storing and security of medicines. Regular medication audits were carried out with the support of the local clinical commissioning group (CCG) pharmacy team to ensure the practice was prescribing in line with best practice guidelines.

Prescription pads were securely stored and there were systems in place to monitor their use. Appropriate procedures were in place for the production of prescriptions and dispensing of medicines. These were up to date and reflected current practice.

The practice was signed up to the Dispensing Services Quality Scheme to help ensure that dispensing related activities were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

The dispensary was managed by a pharmacist. They worked in partnership with the GPs to deliver an integrated medicines optimisation service for patients. For example, the pharmacist provided advice to patients who had been prescribed new medicines to ensure they knew how to take them safely and effectively. Additionally, they were able to fast track patients to see a GP when patients raised

Are services safe?

concerns with them. We received positive feedback from patients in respect of the dispensing service provided and a 95% satisfaction rate had been achieved from a recent survey.

The practice had established a service for patients to pick up their dispensed prescriptions at a local village post office and had systems in place to monitor how these medicines were collected. Medicines were also delivered to patients in their homes by volunteer drivers. Arrangements were in place to ensure these patients were given all the relevant information they required.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and standard operating procedures that set out how they were managed were in place. We found these were being followed by the practice staff.

We saw a very positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This ensured that appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. 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. For example, use of personal protective equipment including disposable gloves, aprons and coverings; and procedures to follow in the event of a needle stick injury.

One of the practice nurses was the infection control clinical lead and most staff had received up to date training. Infection control audits were undertaken and action was taken to address any improvements identified as a result. We however found improvements were required to ensure the safe storage of clinical waste bins that were full prior to their disposal.

A risk assessment for legionella had been undertaken and arrangements were in place for the formal testing of water sources to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. All portable electrical equipment was tested to ensure they were safe to use and clinical equipment was calibrated to ensure it was working properly.

Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The five files we reviewed showed appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). 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.

Staffing

The practice had experienced significant changes to its staffing structure and this included:

- 60% of the GPs being recruited within the last 24 months to cover retirement and maternity leave for example.
- 80% of the practice nurses were recruited within the last 18 months due to resignations and
- 50% of reception staff (referred to as patient care advisors) were recruited to ensure sufficient cover.

Feedback from both patients and staff confirmed there had been occasions where there was not enough staff to maintain the smooth running of the practice. Examples of issues included difficulty in accessing suitable appointments with clinicians, limited access to specialist nurses and increased staff workload.

The management acknowledged the challenges they had experienced and felt the recent recruitment of staff would ensure that sufficient staffing levels were in place to keep patients safe. Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Are services safe?

Monitoring safety and responding to risk

The practice had health and safety procedures in place to manage and monitor risks to patients, staff and visitors to the practice. These included a variety of risk assessments to monitor the safety of the premises, environment and the control of substances hazardous to health (COSHH).

A health and safety compliance audit was completed by an external company in April 2015 and an action plan recommended areas of improvement. We found most of these recommendations had been completed including risk assessments for lifting equipment, slips, trips and falls. Identified risks were assessed and mitigating actions recorded to reduce and manage the risk.

Meeting minutes showed risks were discussed at practice meetings although a few staff felt that training on health and safety could be improved on to ensure they were fully aware of their responsibilities and the actions to take when needed.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions and or those experiencing poor mental health. Staff gave us examples of referrals made for patients whose health deteriorated suddenly including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

Records reviewed showed all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm) and oxygen with adult and children's masks. Staff knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. 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 and major incidents that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. The plan also contained relevant contact details for staff to refer to.

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

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 providing care and treatment for patients. Care was planned to meet identified needs and patients were reviewed at required intervals through a system of regular clinical meetings to ensure their treatment remained effective. This was reflected in clinical meeting minutes we reviewed.

Staff were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Systems were in place to ensure all clinical staff were kept up to date.

The nursing team managed the care of patients with long term conditions such as diabetes and asthma with support from the GPs and specialist nurses. There was a robust recall system in place to identify and invite patients for their clinical review in their birth month.

Two of the GP partners had received specific training from Lincolnshire social services to carry out health assessments for looked after children. These assessments identified any ongoing or new health issues and ensured the children and their carers were able to access appropriate treatment when required.

Management, monitoring and improving outcomes for people

Although audits linked to medicines management were undertaken, the practice had a limited programme in place for undertaking full cycle clinical audits covering other areas of clinical practice. The practice showed us five clinical audits that had been undertaken in the last 14 months. One of these was a completed audit cycle (quinolone anti-biotic prescribing) but minimal changes had been made since the initial audit.

The practice participated in the Quality and Outcomes Framework (QOF) and used the information collected to monitor outcomes for patients. 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. Practice supplied data showed 92.19% of the total number of points for clinical indicators had been achieved for 2014/15; although this was yet to be verified and published.

Comparable QOF data for 2013/14 showed the practice had achieved a total of 89.5% which was below the clinical commissioning group (CCG) average of 95.3% and national average of 93.5%. The data also showed high rates of clinical “exception reporting” for conditions such as chronic kidney disease, osteoporosis, dementia and hypertension. Exception reporting ensures practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a side-effect.

Our review of patient records showed the clinical judgement for the exception reporting was relevant to the patient, clearly documented and in line with the recommended guidance. In some cases, inaccurate codes had been assigned to the patient record and this had been addressed and shared with staff as learning.

The practice had adopted the “Year of Care” model for patients with diabetes; as part of a CCG initiative. This model aims to empower patients to be actively involved in the planning of their care. Patients received a review of their health needs and medicines, a copy of their care plan, test results and related information. Staff told us this encouraged patients to take responsibility for the self-management of their condition and to be aware of when to seek help. This model had only been implemented within the last month; therefore limited data was available to demonstrate the full impact on patient outcomes.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. For example, the practice had lower rates for accident and emergency (A&E) attendances and elective emergency admissions compared to the CCG and Nottinghamshire county averages.

Improvement work had been undertaken to minimise the referral rates to secondary care as these had been higher compared to some of the local practices. Meetings to discuss patient referrals were held at least twice monthly to ensure appropriate referrals were made by the clinicians.

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Suitable systems were in place to ensure that staff had the skills, knowledge and experience to deliver effective care and treatment. This included;

- An induction programme for newly appointed members of staff. This entailed shadowing experienced members of staff, use of mentors and the review of key policies and procedures such as information governance awareness and confidentiality.
- Staff records showed their learning needs were identified through a system of regular supervision meetings and appraisals. Staff employed for over a year had an appraisal within the last 12 months and action plans were documented.
- Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included use of e-learning training modules, in-house and external training and clinical supervision for clinicians. Staff confirmed the practice was proactive in providing training that was relevant for their role.
- Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and 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 seeing patients with long-term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.
- GPs were up to date with their continuing professional development requirements and had either 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.

Working with colleagues and other services

The practice held a range of monthly multi-disciplinary team meetings to discuss patients with complex health needs and their on-going care and treatment. This included patients with multiple long term conditions and / or experiencing poor mental health. These meetings were attended by health visitors, a complex case manager,

practice nurses, a care coordinator and GPs for example. Care plans were routinely reviewed and updated; and shared with other health and social care workers as appropriate.

The practice was working towards the gold standards framework for end of life care. It had a palliative care register and regular multidisciplinary meetings were held to discuss the care and support needs of patients and their families. This also included liaison with Macmillan nurses.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients' needs were regularly assessed and reviewed at monthly multi-disciplinary meetings to ensure integrated care was delivered. These meetings were referred to as PRISM (Profiling Risk, Integrated Care and Self-Management) and 1.9% of patients identified as being at high risk of admission to hospital had care plans in place. Systems were in place to ensure the needs of patients discharged from hospital continued to be met.

Information sharing

Prior our inspection, we received feedback from three patients highlighting that referrals to secondary care had not always been processed in a timely way.

Our review of the practice's records showed the information needed to plan and deliver care and treatment was available to relevant staff in a timely way on most occasions; and this was accessible through the practice's patient record system and their intranet system. This included: use of an electronic patient record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference by clinicians.

The practice told us they had experienced IT problems when the NHS e-referral service, the successor to Choose and Book, was launched in June 2015. This had resulted in the delay of processing some referrals and we noted that appropriate follow ups were made.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with relevant legislation and guidance. This included the Mental Capacity Act 2005 and the Children Acts 1989 and

Are services effective?

(for example, treatment is effective)

2004. Where a patient's mental capacity to consent to specific care or treatment was unclear this was assessed and the outcome was recorded. This included do not attempt resuscitation orders.

Best interest decisions were made if a patient was assessed as not having the capacity to make a specific decision due to a cognitive impairment or advanced dementia.

The practice obtained written consent for significant minor procedures and were reviewing their procedures to include injections. Clinical staff we spoke with were clear about when to obtain written consent and documenting the discussion about the relevant risks, benefits and possible complications of the procedure.

Patients with a learning disability were supported to make decisions through the use of care plans, which they were involved in agreeing including their carers / next of kin where appropriate. At the time of our inspection, 34 patients were identified as meeting the learning disabilities criteria for 2014/15. Thirteen patients had been reviewed, five patients had booked appointments and the remaining others were due for review by 31st March 2016.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. This included patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol intake. Patients were signposted to the relevant service including weight management and smoking cessation advice. The practice had identified the smoking status of 659 patients over the age of 15 and 377 (57.2%) had received smoking cessation advice.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Although practice data showed a total of 42.7% eligible patients had received a check, comparative data for 2014/15 showed the number of health checks undertaken were higher than the CCG average. We were shown examples to demonstrate that appropriate follow-ups were made when abnormalities or risk factors were identified during the health assessment.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening of which comparable rates to the CCG and national averages had been achieved. For example, the practice's performance for the cervical screening programme for patients aged 25 to 64 was 78.06% compared to the national average of 81.88%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice had achieved comparable rates to the CCG data for the majority of immunisations.

Childhood immunisation rates for the vaccinations given to under twos ranged from 96% to 96.6% and five year olds from 88.7% to 90.1%. We however noted that no reminders were issued for childhood immunisations for one year olds and the pre-school booster to ensure attendance.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 12 patients during our inspection and most of them were satisfied with the care received. They told us their dignity and privacy was respected; and described most staff as being friendly, caring and helpful. We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

We received 11 comment cards of which: three cards contained positive comments, five contained mixed views and three contained less positive feedback about the standard of care received. Most comment cards highlighted staff responded compassionately when they needed help and provided support when required. Eight comments were less positive and common themes related to poor phone access and long waiting times to obtain a routine appointment with a GP or nurse.

Patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw that curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. The doors were also closed during consultations and conversations taking place in these rooms could not be overheard. Reception staff told us a private room was offered if patients wanted to discuss sensitive issues or appeared distressed.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015 and the practice's 2014 survey which was undertaken by an independent company. The evidence from all these sources showed most patients were satisfied with how they were treated and this was with compassion, dignity and respect. The practice survey showed staff were polite and considerate, and reception staff were helpful.

Results from the national GP patient survey showed most patients were happy with how they were treated. The practice was in line with the local and national averages for its satisfaction scores on consultations with doctors and nurses.

- 89% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 87% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%

Comparable scores were also achieved for satisfaction scores on consultations with nurses; and the practice's own survey.

Care planning and involvement in decisions about care and treatment

Most patients we spoke with told us their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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 were also positive and aligned with these views.

The national patient survey results also showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 84% 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 81%.

Most of the care plans we reviewed showed evidence of patient and / or carer involvement in agreeing these and information about end of life planning were appropriate. However, care plans for people experiencing poor mental health were not always personalised and easy to confirm the arrangements in place for the delivery of their care, treatment and support.

Patient/carers support to cope emotionally with care and treatment

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

Are services caring?

- 88% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

Most of the patients we spoke with and the comment cards we received were also consistent with this survey information. The practice also received cards, notes and flowers of thanks and gratitude from patients in acknowledgement of the support provided.

Notices in the patient waiting room and patient website told patients how to access a number of community support groups and organisations to address their emotional and social needs. This included the “men in sheds” project which supports older men to socialise, share and learn new skills so as to reduce isolation and improve their mental wellbeing.

The practice’s computer system alerted GPs if a patient was a carer and written information was available for carers to ensure they understood the various avenues of support available to them. Carers were offered health reviews and referred for social services support where appropriate.

Staff told us that if families had experienced bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family’s needs and/or by giving them advice on how to find a support service. One patient we spoke with confirmed they had received this type of support and said they had found it helpful during their bereavement.

The practice was also in the process of developing a bereavement protocol as part of the gold standards framework “Going for Gold” practice accreditation to ensure better care for vulnerable patients in the final years of their life.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had an on-going programme to ensure that services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. An outstanding feature we noted was the provision of a volunteer transport service coordinated by the practice and the patient participation group; referred to as the Collingham Village Care Committee (which is also a registered charity).

The Collingham village care community car scheme is run by volunteers for patients registered with the practice who struggle to access public transport and need alternative transport. A team of volunteer drivers use their own cars to support patients attend a range of health related appointments and social activities including waiting for them. This enabled patients to retain their independence and to access community services.

At the time of our inspection there were 18 drivers, 250 registered patients and 256 trips had been undertaken to hospitals and the GP practice. This feature was outstanding in that the service provision went beyond the normal scope of clinical practice and the practice used additional resources available to them including grants and bequests to ensure patients within the rural community were supported to access health services.

- A range of in-house services were offered including:
- remote monitoring of blood pressure via a text message (referred to as Florence telehealth service) of which 88 patients had accessed this service within the last 12 months. Additionally 62 patients had received 24 hour blood pressure monitoring which enabled them to be monitored closer to home without having to attend a hospital appointment.
- family planning, ante-natal and post-natal care.
- nurse-led clinics for monitoring long term conditions such as asthma, hypertension and diabetes; as well as minor illnesses.
- minor surgery, dressings and removal of stitches.
- infant and adult immunisations and a travel clinic.

The practice also hosted the following community services enabling patients to access services within the same building: physiotherapy, podiatry including toe nail cutting

services, osteopath, hearing services (tests and aids), counselling, pain management and library services. The practice described this as a “one stop shop” and had strong links with other professionals to ensure patients received an integrated service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities, people experiencing poor mental health and those with complex health needs. The majority of the practice population had English as their first language but access to translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice premises were purpose built and accessible to patients with mobility difficulties. Facilities included use of automatic doors, consultation rooms on the ground floor and sufficient space for wheelchairs. A portable induction loop system was also available. Baby changing facilities were available in the disabled toilet.

There was one male GP and five female GPs in the practice and one comment card highlighted this meant less choice if they wished to consult with a male GP only.

Although staff demonstrated awareness of anti-discriminatory practice, records reviewed showed staff had not received equality and diversity training.

Access to the service

The practice was open between 8.15am and 5.30pm Tuesday to Friday; and up to 7pm on a Monday. Appointments were from 8.30am to 11.10am every morning and 3.30pm to 7pm daily. Extended hours were offered on Monday between 5.30pm and 7pm.

The practice website contained useful information on the opening hours, appointment times, how to arrange home visits and book appointments. Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed.

The patient survey information we reviewed showed satisfaction scores to questions about access to appointments were mostly lower than the local and national averages.

Are services responsive to people's needs?

(for example, to feedback?)

- 66% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 64% described their experience of making an appointment as good compared to the CCG average of 71% and national average of 73%.
- 63% said they could get through easily to the surgery by phone compared to the CCG average of 63% and national average of 73%.
- 56% said they usually waited 15 minutes or less after their appointment time compared to the CCG and national averages of 65%.

Comparable values were achieved for the following areas;

- 84% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG national average of 85%.
- 90% say the last appointment they got was convenient compared to the CCG average of 90% and national average of 92%.

This data was aligned with the patient feedback we received. Some patients we spoke with confirmed they could see a doctor on the same day if in need of urgent care and treatment and had been able to access an appointment that was convenient to them.

However, most of the patients we spoke with were not satisfied with the phone access and appointment system. They highlighted it took: "long" for their phone calls to be answered by staff; the line could be engaged "for ages"; long waiting times for appointments and up to five weeks waiting time to obtain a non-urgent appointment with a GP. This was also aligned with comment cards received and regular concerns were raised with the Councillor for the area.

The management team were already aware of the concerns and had changed the appointment system from 01 July 2015 as a result. The new appointment system included offering an increased number of same day appointments and limiting pre-bookable appointments to three weeks in advance. Staff felt the new system was much better in that they were able to offer more same day appointments and received fewer complaints from patients.

Our overall review of the phone access and appointment system showed although changes had been made in response to patient feedback and increased staffing levels, improvements were still required, in particular:

- regular audits to assess, monitor and improve the quality of patients' experience of accessing the service and demand analysis for appointments as these had not been consistently undertaken within the last 18 months.
- Wider patient engagement regarding changes to phone access and the appointment system. Our discussion with patients showed some were not aware of the changes and others felt appointments were available due to the summer holidays when some patients were not around. Older people we spoke with felt that limiting pre-bookable appointments was not convenient for them.

Listening and learning from concerns and complaints

Although the practice had a system in place for handling complaints and concerns, improvements were still required. The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the lead person who handled all complaints in the practice and complaints were discussed as significant events.

We looked at complaints received in the last 15 months and found these were handled satisfactorily and discussed with the wider staff team. Learning from complaints was clearly recorded and lessons learned from individual complaints had been acted on to improve the quality of care.

Additionally, an annual review of complaints and learning points was discussed during a practice meeting in April 2015 of which themes were detected. However detailed records of verbal complaints dealt with were not always maintained.

There was no available information such as posters and summary leaflets within the practice to help patients understand the complaints system. Some patients we spoke with were not aware of the process to follow if they wished to make a complaint; however highlighted they would liaise with the GP or staff. Feedback received from two patients after our inspection showed complaints were not always dealt with in a timely manner.

Are services well-led?

Good 

(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 clear vision to deliver high quality care and promote good clinical outcomes for patients. This included values such as: putting “patients’ needs at the heart of everything we do”; treating all persons with dignity and respect and partnership working with other health professionals. The mission statement was displayed in the waiting area and visible to patients.

Most staff we spoke with understood the vision and values and knew what their responsibilities were in relation to these. The vision and practice values were part of the practice’s development plan which was regularly reviewed. Meeting minutes showed that staff had discussed and agreed the vision at an away day held on 9 July 2014. The practice was fully aware of its strengths and challenges and action plans were in place to make improvements.

Governance arrangements

The practice had an overarching governance framework which had been improved on to support the delivery of good quality care. This outlined the structures in place and ensured:

- There was a clear leadership structure with named members of staff in lead roles. For example, the GP partners and practice manager took an active leadership role for monitoring the quality of the service. A range of governance team meetings were held monthly and action plans were produced to maintain or improve outcomes. This covered areas such as pharmacy clinical governance, patient feedback and delivery of patient care.
- There was a clear staffing structure and staff we spoke with were clear of their own roles and responsibilities
- Practice specific policies and procedures were in place to govern both clinical and non-clinical activities. Policies we reviewed were up to date, accessible to all staff implemented as planned.
- The management had a good understanding of the performance of the practice. They utilised performance data to review patient outcomes. However, improvements were required to ensure an ongoing programme of full cycle clinical audits was completed.
- There were suitable arrangements in place for identifying, recording and managing risks and implementing mitigating actions.

- The practice had a whistleblowing policy available to all staff. Whistleblowing concerns had been shared with external bodies including the General Medical Council, Clinical Commissioning Group, NHS England and the Care Quality Commission. Appropriate investigations had been undertaken to address the concerns raised.

Leadership, openness and transparency

The practice had increased its staffing levels to ensure staff had the experience, capacity and capability to run the practice and deliver good quality care. The partners in the practice were visible in the practice and most staff told us they were approachable and took the time to listen them.

Although the partners encouraged a culture of openness and honesty, some staff felt the recent changes including staffing could have been better communicated and handled. Two staff gave examples of how they felt that team development was still in the process of being embedded due to significant staffing changes within the last 24 months.

Most staff were involved in discussions about how to improve the service delivered by the practice. Regular practice meetings were held at least monthly and a meeting schedule had been agreed up to December 2015. Staff said they felt respected, valued and supported on most occasions by the leadership.

Seeking and acting on feedback from patients, public and staff

The practice gathered feedback from patients through surveys, complaints and the patient participation group (PPG), also known as the Collingham and District Village Care Committee. 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 PPG was active and comprised of 44 members; with some members attending face to face meetings and others receiving communication via email.

We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the staff and in shaping the service delivered at the practice. The practice also produced a newsletter containing a summary of the patient comments, suggestions and the action taken by the practice to address this. This covered areas such as Saturday morning clinics, car parking facilities, telephone access and appointments.

Are services well-led?

Good 

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

Most staff told us they felt involved and engaged in the practice to improve outcomes for patients as well as improve how the practice was run. For example, same day appointments were introduced for the assessment of wound care following staff feedback and an audit which showed a growing demand for dressings, suture removals and follow-up of patients who had received acute hospital interventions.

Management lead through learning and development

There was a focus on continuous learning and improvement at all levels within the practice; and this was one of the practice's key values. The practice team was forward thinking and took part in local pilot schemes to improve outcomes for patients in the area.

- Hosting a range of community services within the practice to promote delivery of integrated services for patients closer to home.
- use of emergency care practitioners (ECPs) to support acute home visits for acutely unwell and older patients
- participating in Prime Minister's winter challenge fund to provide additional clinics on a Saturday to the patients
- active engagement with the PPG in respect of patient education and surveys regarding provision of community services. For example, hosting of "warm wise and well events" and health talks on a range of health conditions.

The practice is a GP teaching and training practice; and also offers placements as part of practice nurse training and pre-registration for pharmacists. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>We found further improvements were required from the registered person to ensure:</p> <ul style="list-style-type: none">• systems related to the assessment, review and monitoring of phone access and the appointment system were undertaken and communicated to patients to improve their understanding and experience.• full cycle clinical audits were undertaken and used to drive improvements. <p>This was in breach of regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints</p> <p>We found the registered person did not have easily accessible system for providing people who use the service with information about how to complain, verbal complaints were not always fully recorded and a few complaints had not been responded timely.</p> <p>This was in breach of regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>