South Axholme Practice

Quality Report

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

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?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The practice was previously inspected on 2 February 2015 and the overall rating was Requires improvement.

We carried out an announced comprehensive inspection at South Axholme Practice on 18 August 2016. Overall the practice is now rated as good.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, the learning from reviews and investigations was not always embedded.

• Risks to patients were not always assessed and well managed. There was no documented evidence of national patient safety alerts having been actioned.

• Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.

• Patients said they were treated with compassion,dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand. Some improvements were made to the quality of care as a result of complaints and concerns but these were not shared with all staff and embedded.

• Patients said access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.

• The practice had good facilities and was well equipped to treat patients and meet their needs.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

• The provider was aware of and complied with the requirements of the duty of candour.

Summary of findings

• The practice had policies and procedures in place. However, we found some procedures were not always followed in terms of the recruitment of staff and the management of some medicines.

The areas where the provider must make improvements are:

• Ensure arrangements are in place for the safe management of some medicines.

• Ensure recruitment arrangements include obtaining two references for all staff.

The areas where the provider should make improvement are:

• Check that measures introduced following incidents are maintained and evaluated for effectiveness.

• Review the frequency of basic life support training to ensure it follows best practice guidelines as laid down by the Resuscitation Council (UK).

• Ensure action is taken to proactively identify carers registered at the practice.

• Review the arrangements in place for the safe management of sterile equipment.

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?

Good

The practice is rated as good for providing safe services

• Staff understood their responsibilities to raise concerns, and to report incidents and near misses.

• The practice manager would forward safety alerts to relevant staff however there was not a system in place to ensure these had been actioned.

• When things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.

• Although risks to patients who used services were assessed, the systems and processes to address these risks were sometimes not implemented well enough to ensure patients were kept safe. For example medicines were not always safely managed, some sterile equipment was out of date, basic life support training was out of date.

• Recruitment arrangements did not include all necessary employment checks for all staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

• Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.

• Staff assessed needs and delivered care in line with current evidence based guidance.

• Clinical audits demonstrated quality improvement.

• Staff had the skills, knowledge and experience to deliver effective care and treatment.

• There was evidence of appraisals and personal development plans for all staff.

• Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated good for providing caring services.

• Data from the national GP patient survey showed patients rated the practice as comparable to others for several aspects of care.

Summary of findings

• 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

• We were told the practice was not proactive in reaching out to the wider practice population to encourage carers to register.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

• Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.

• Feedback from patients 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.

• The practice had good facilities and was well equipped to treat patients and meet their needs.

• Information about how to complain was available on the website and at two branch surgeries. The information was easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was not shared with all staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

• The practice had a mission statement but not all staff were aware of it. There was a clear leadership structure and staff felt supported by management.

• The practice had a number of policies and procedures to govern activity and held regular meetings at which governance was discussed.

• The arrangement for governance did not always operate effectively. For example, we found some structures and processes were not always followed and we found issues still outstanding from the previous inspection for example following the recruitment policy and procedure fully.

• The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty.

Summary of findings

• The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken. There was no documented evidence of national patient safety alerts having been actioned.

• The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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

Good

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

• The practice offered proactive, personalised care to meet the needs of the older people in its population.

• The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

People with long term conditions

Good

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.

• 82% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (01/04/2014 to 31/03/2015). This was worse than the CCG average of 87% and the national average of 88%.

• 71% of patients with asthma, on the register, had an asthma review in the preceding 12 months that included an assessment of asthma control using the 3 RCP questions. (01/04/2014 to 31/03/2015). This was is similar to the CCG and national averages of 75%.

• Longer appointments and home visits were available when needed.

• All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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 who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Summary of findings

• 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.

• 83% of women aged 25-64 notes record that a cervical screening test has been performed in the preceding 5 years (01/04/2014 to 31/03/2015). This was similar to the CCG average of 79% and better than the national average of 74%.

• Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

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, 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

Good

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

• The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

• The practice offered longer appointments for patients with a learning disability.

• The practice regularly worked with other health care professionals in the case management of vulnerable patients.

• The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

•Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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.

People experiencing poor mental health (including people with dementia)

Good

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

Summary of findings

• 74% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months, which is worse than the CCG average of 87% and national average of 90%.

• 88% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015). This was similar to the CCG average of 86%and the national average of 88%.

• The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

• The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

•Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the performance of the practice was mixed compared with local and national averages. 239 survey forms were distributed and 125 were returned. This represented 1% of the practice's patient list.

• 91% of patients found it easy to get through to this practice by phone compared to the CCG average of 70% and the national average of 73%.

• 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 73% and the national average of 76%.

• 89% of patients described the overall experience of this GP practice as good compared to the compared to the CCG and national averages of 85%.

• 90% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG and national averages of 79%.As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.We received 20 comment cards which were all positive about the standard of care received and thought staff were approachable, committed and caring. The most recent three months results of the Friends and Family Test showed that 90% of patients were likely or extremely likely to recommend the practice to their friends and family.

Areas for improvement

Action the service MUST take to improve
The areas where the provider must make improvements are:

• Ensure arrangements are in place for the safe management of medicines.

• Ensure recruitment arrangements include all necessary employment checks for all staff.

Action the service SHOULD take to improve
The areas where the provider should make improvement are:

• Check that measures introduced following incidents are maintained and evaluated for effectiveness.

• Review the frequency of basic life support training to ensure it follows best practice guidelines as laid down by the Resuscitation Council (UK).

• Ensure action is taken to proactively identify carers registered at the practice.

• Review the arrangements in place for the safe management of sterile equipment.

South Axholme Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and the team included a GP specialist adviser, a practice nurse specialist adviser and a pharmacist specialist adviser.

Background to South Axholme Practice

South Axholme Practice is situated in Epworth, a small town and civil parish in the Isle of Axholme, North Lincolnshire. The practice also has four branch surgeries in nearby areas of Belton, Haxey, Owston Ferry and West Butterwick. There are 14722 patients on the practice list.The practice is a dispensing practice.

The practice scored nine on the deprivation measurement scale, the deprivation scale goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have a greater need for health services.

Staffing is made up of seven GP partners, and three salaried GPs. Five of the GPs are female and five are male. The practice also employ an emergency care practitioner, a nurse practitioner, an assistant practitioner, four practice nurses, five health care assistants, twelve dispensary staff, a range of administrative and reception staff along with a practice manager and deputy practice manager.

South Axholme is a training practice and provides placements for Foundation Year 2 trainees and GP registrars. The practice has a general medical service (GMS) Contract.

The main surgery is at Epworth and is open 8am- 7pm Monday to Thursday and 8am- 6.30pm on Friday. The practice provides regulated activities from the following branches

• 30 Church Street, Haxey DN9 2HY. Open Monday to Wednesday 8.30am- 12.30pm and 1.30pm- 5.30pm and 8.30am- 12.30pm Thursday and Friday.

• 32 High Street, Belton DN9 1LR. Open Monday to Friday 8.30am-12.30pm.

• Pinfold Surgery, Station Road, Owston Ferry DN9 1AW. Open Monday to Friday 8.30am- 12.30pm and Monday 1.30pm- 6pm.

• Jubilee Surgery, School Lane, West Butterwick DN17 3LB(not visited). Open Monday, Wednesday and Friday 8.30am-12pm.

When the practice is closed, patients are instructed to ring NHS 111. Information for patients requiring urgent medical attention out of hours is available in the waiting area, in the practice information leaflet and in exterior notice boards.

The practice was previously inspected on 2 February 2015 and the overall rating was Requires improvement.

• This consisted of Inadequate rating for Safe in regard to the safe management of medicines and criminal record checks not being made for some staff.

• Requires improvement for Effective in regard to lack of clinical supervision.

• Good for Caring and Good for Responsive.

• Requires improvement for Well-Led in regard to process associated with the safe recruitment of staff, medicines management, carrying out legionella testing and responding appropriately to advice from the fire service.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 August 2016.

During our visit we:

• Spoke with a range of staff (GPs, practice manager,nurse practitioner, emergency care practitioner, practice nurse, healthcare assistant and dispensary staff) and spoke with patients who used the service.

• Observed how patients were being cared for and talked with carers and/or family members.

• Reviewed an anonymised sample of the personal care or treatment records of patients.

• Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care 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 were provided for specific groups of people and what good care looked 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).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording events. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

• We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

• The practice carried out a thorough analysis of the significant events but we found that arrangements were not in place to check that measures introduced following incidents were maintained or evaluated for their effectiveness. For example, the practice had two significant events regarding the prescribing of high risk medicine. These incidents were five months apart thus the practice had failed to identify that the action taken to prevent recurrence of such an incident had been unsuccessful. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw some evidence that lessons were shared and action was taken to improve safety in the practice. The practice manager would forward safety alerts to relevant staff however there was no documented evidence that these had been actioned.

Overview of safety systems and processes

The practice had some processes and practices in place to keep patients safe and safeguarded from abuse. Some processes were not followed by staff.

• Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements.Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level 3. Nurses were trained to child protection or child safeguarding level 2.

•A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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 maybe vulnerable).

• The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

• We checked arrangements for managing medicines at the practice. The practice had four sites with dispensaries; we visited three of these during our inspection. Prescriptions were dispensed for patients who lived more than 1.6km from a pharmacy and this was appropriately managed.

• Standard Operating Procedures (SOPs), which covered all aspects of the dispensing process, were in place and recently reviewed (these are written instructions about how to safely dispense medicines). Dispensing staff were aware prescriptions should be signed before being dispensed and a procedure was in place to ensure this occurred. We observed all the prescriptions ready to be collected were signed. This was an improvement from our previous inspection. There were sufficient staff to ensure a second checking system was used to provide dispensing accuracy assurances wherever possible. We saw a process was in place to monitor any uncollected prescriptions and these were followed up appropriately. The practice made reasonable adjustments for patients who struggled to manage their own medicines, for example by providing monitored dosage systems.

Good

Are services safe?

• The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. There was a named GP responsible for the dispensary. . Members of staff involved in the dispensing process had received appropriate training. Staff told us they received annual appraisals and competency assessments. Audits were completed regularly on a range of topics.

• Medicines reviews in line with DSQS guidelines were carried out by GPs and records were kept on the patient's electronic record. There was a process in place for patient's requesting medicines outside their review date. However, this allowed patients to receive medicines for up to three months after their review date had passed; we discussed this with staff during our inspection and were told the standard operating procedure for this would be reviewed.

• Stocks of Controlled Drugs (CDs, medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely and SOPs set out how they were managed. However, we saw balance checks of controlled drugs had not been carried out at the Belton dispensary since December 2015. This was not in line with the practice policy. We also noted that staff had not written the date of opening on two bottles of controlled drug liquid so could not confirm if the medicine had expired. Staff told us this would be reported to the practice manager and the medicine separated for destruction. There were appropriate arrangements in place for destruction of CDs.

• We found medicines were stored securely across the sites we visited.

• Staff kept a 'near-miss' record (a record of errors that have been identified before medicines have left the dispensary). Dispensing errors were also appropriately recorded. These were shared with staff, however these were not reviewed to identify themes and leaning to prevent recurrence. Practice staff told us they would start to do this. Staff told us they responded appropriately to national patient safety alerts however there was no documented evidence that this had happened. The practice was reviewing systems for the management of high risk medicines as part of the dispensing process.

• Oxygen and a defibrillator were available for use at the practice and were easily accessible. We checked emergency medicines stored in the treatment rooms at three sites. There was a procedure in place to ensure emergency medicines were fit for use. However, we found this procedure was not always correctly followed which resulted in some emergency medicines being out of date.

• Medicines requiring refrigeration were stored appropriately and staff told us about actions being taken where dispensary room temperatures had been identified as higher than recommended.

• Blank prescription forms were handled in accordance with national guidance and the practice kept them securely. A process was in place to track prescription forms through the surgery.

• We reviewed three personnel files of staff recruited since 1 May 2015. At the previous inspection we identified a shortfall in the recruitment of staff. Whilst progress had been made and DBS checks have been completed prior to commencing employment, we found the provider was not always following its own recruitment policy regarding obtaining two references from previous employers. We found two occasions when only one was obtained and one where none had been obtained.

Monitoring risks to patients

The practice had some arrangements in place to assess and manage risks.

• There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

• Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had arrangements in place to respond to emergencies and major incidents.• There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

• The practice had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available.

• Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines were stored securely but not all we checked were in date.

•The practice should review the frequency of their basic life support training to ensure it follows best practice guidelines as laid down by the Resuscitation Council. At the time of the inspection, the training was overdue for 85% (49 out of 57) staff.

• The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

• The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92% of the total number of points available which was similar to the England average of 94%. Exception reporting rates were comparable to CCG and national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets.

Data from 2014/15 showed:

• Performance for diabetes related indicators was similar to the national average. (Practice rate is 87% compared to the CCG average of 90% and the national average of 89%).

• Performance for mental health related indicators similar to the CCG and national averages. (Practice rate is 89%compared to the CCG average of 91% and the national average of 93%).

There was evidence of quality improvement including clinical audit.

• There had been two clinical audits completed in the last two years, both of these were completed audits where the improvements made were implemented and monitored. The practice did not have any arrangements in place to identify which topics to audit or to link it to current practice or concerns.

• The practice participated in local audits, national benchmarking and accreditation.

• Findings were used by the practice to improve services.For example, recent action taken as a result included a change of policy to ensure patients with a vitamin deficiency received monitoring in line with NICE guidance.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.• The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

• The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, those reviewing patients with diabetes had undertaken disease-specific diplomas.

• Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

• The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Almost all staff had received an appraisal within the last 12 months.

• Staff received training that included safeguarding and fire safety awareness. Annual basic life support training was overdue for 49 out of 57 (85%) staff. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

Good

Are services effective?

(for example, treatment is effective)

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

• This included care and risk assessments, care plans,medical records and investigation and test results.

• The practice shared relevant information with other services in a timely way, for example when referring patients to other services. Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

• Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

• When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

• Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet and smoking cessation were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 83%, which was comparable to the CCG average of 79% and better than the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability. They ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example,childhood immunisation rates for the vaccinations given to under two year olds ranged from 91% to 98% and five year olds from 89% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

• Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations,investigations and treatments.

• We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

• Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was similar to average for its satisfaction scores on consultations with GPs and nurses.For example:

• 92% of patients said the GP was good at listening to them compared to the CCG average of 89% and the national average of 89%.

• 86% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.

• 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.

• 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 85%.

• 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%

.• 85% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients had mixed responses to questions about their involvement in planning and making decisions about their care and treatment. For example:

• 87% of patients said the last GP they saw was good at explaining tests and treatments. This is comparable to the CCG average of 86% and the national average of 86%.

• 89% of patients said the last GP they saw was good at involving them in decisions about their care. This is better than the CCG average of 79% and the national average of 82%.

• 77% of patients said the last nurse they saw was good at involving them in decisions about their care. This is worse than the CCG average of 86% and the national average of 85%. The practice had no plans in place to improve this.

The practice provided facilities to help patients be involved in decisions about their care. For example, information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 0.5% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

• There were longer appointments available for patients with a learning disability.

• Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.

• Same day appointments were available for children and those patients with medical problems that require same day consultation.

• Patients were able to receive travel vaccinations available on the NHS.

• There were disabled facilities and translation services available.

Access to the service

The main surgery is at Epworth and is open 8am- 7pm Monday to Thursday and 8am- 6.30pm on Friday. In addition to pre-bookable appointments that could be booked up to three weeks in advance, urgent appointments were also available for people that needed them.

The branch practices are open:

•30 Church Street, Haxey DN9 2HY. Open Monday to Wednesday 8.30am- 12.30pm and 1.30pm- 5.30pm and 8.30am- 12.30pm Thursday and Friday.

• Belton Branch surgery is open Monday to Friday 8.30am-12.30pm.

• Pinfold Surgery is open Monday to Friday 8.30am-12.30pm and Monday 1.30pm- 6pm.

• Jubilee Surgery is open Monday, Wednesday and Friday 8.30am-12pm.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was similar or above local and national averages.

• 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 78%.

• 91% of patients said they could get through easily to the practice by phone compared to the CCG average of 70%and the national average of 73%.

The practice had a system in place to assess:

• whether a home visit was clinically necessary and

• the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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.

• We saw that information was available to help patients understand the complaints system on the practice website. Posters were displayed at two of the branch surgeries but not elsewhere.

We looked at 19 complaints received in the last 12 months and found these were dealt with in a timely way. There was limited evidence to demonstrate learning from individual concerns and complaints.

Are services well-led?

Requires improvement

(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 care and promote good outcomes for patients.

• The practice had a mission statement but not all staff were aware of it.

• The practice had a strategy and supporting business plans which reflected the vision and values.

Governance arrangements.

We found some of the structures and processes in place at the practice were not always followed:

• Practice specific policies were available to all staff and most were implemented but we found a log book in which emergency medicines had been recorded as being in date when some were out of date.

• The practice provided us with examples where the practice had implemented changes following events and complaints. However, we found one example where the changes the practice told us they had implemented were not working in practice on the day of our inspection and therefore the risk had not been mitigated.

• The practice had two significant events regarding the prescribing of high risk medicine. These incidents were five months apart, the practice had failed to evaluate the measures put in place from the first significant event in order to prevent recurrence and mitigate risks to patients.

• Some areas for improvement from the previous inspection had not been actioned fully. For example the recruitment policy was not being followed fully as we found newly recruited members of staff had commenced employment without sufficient references being taken. At the previous inspection we identified that staff had not had appropriate checks in terms of a DBS check. At this inspection the DBS checks had been obtained

• Balance checks of controlled drugs had not been carried out at the Belton dispensary since December 2015. This was not in line with the practice policy.

• There was a procedure in place to ensure emergency medicines were fit for use. However, we found this procedure was not always correctly followed which resulted in some emergency medicines being out of date.

• There was a clear staffing structure and that staff were aware of their own roles and responsibilities.

Leadership and culture

The practice told us they prioritised safe, high quality and compassionate care.

Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

• The practice gave affected people reasonable support,truthful information and a verbal and written apology.

• The practice kept records of written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

• Staff told us the practice held regular team meetings.

• Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

• Staff said they felt respected, valued and supported,particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients'feedback and engaged patients in the delivery of the service.

· The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly,

Are services well-led?

Requires improvement

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

carried out patient surveys and submitted proposals for improvements to the practice management team. For example, having a range of seats in waiting areas to better reflect patients' needs.

• The practice had gathered feedback from staff through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

This section is primarily information for the provider

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems and processes did not ensure that measures introduced following incidents were maintained or evaluated for their effectiveness. Regulation 17(2)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The provider had not ensured that the information specified in Schedule 3 was available for each person employed. The recruitment policy and procedure was not being followed as some staff had been recruited without sufficient references being obtained prior to commencement of work at the practice. Regulation 19(2)