Sleaford Medical Group

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?	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 Sleaford Medical Group on 6 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be providing safe, effective, caring, responsive and well led services. It was also good for providing services for all the population groups.

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

- Staff were overwhelmingly positive about the new management structure. There was good evidence of team working. Motivation and enthusiasm was evident during the inspection.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Risks to patients were assessed and well managed.
- 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.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. In the information from the January 2015 national GP survey both GP's and nurses scored highly on satisfaction scores for listening to and giving patients enough time
- Patients said they did not find it easy to make an appointment with the same GP to ensure continuity of care. Urgent appointments were available on 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.

Summary of findings

- The practice had a number of policies and procedures to govern activity, but some were overdue for review.

We saw an area of outstanding practice:

- The practice had identified the need for more reception staff, health care assistants and minor illness nurses and had recently employed these staff. They had also created a new role within the minor illness unit to accommodate specific minor illness home visits carried out by the practice. In order to facilitate this the practice had proactively employed a triage and minor illness nurse trainer on a three year contract. This was in order to train and provide on-going support to a combination of nine existing or newly employed practice nurses in triage and minor illness.

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

The provider should :-

- Ensure clinical audits are completed cycles to demonstrate improvements to patient outcomes.
- Ensure all staff have access to policies, procedures and guidance which are robust, reviewed and updated to enable them to carry out their role, for example, cold chain, infection prevention and control, legionella and COSHH.
- Have appropriate systems in place to ensure standards of cleanliness are maintained and to prevent the risks of infection by; having cleaning schedules in place, finalising the legionella risk assessment and continuing to address infection prevention and control issues (such as cleaning the ear syringing equipment in line with the practice policy.)
- Have a risk assessment in place to ensure the safe management of emergency
- medicines to be administered to patients on home visits.
- Ensure learning from complaints is shared with all staff.
- PPG minutes should be available in the practice and on the practice website.
- The practice should have practice meetings which are regular, structured and relevant to give all staff the opportunity to take part, where information is shared and lessons learnt. For example, significant events, complaints, risk management, infection control and NICE guidance. Meetings should be minuted in order to record summaries of topics discussed and actions to be taken.

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 and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. The practice had systems in place to ensure effective infection prevention and control. The practice had recently employed an external company to carry out a thorough infection control audit. The practice had identified staff responsible for ensuring the actions were carried out within reasonable timescales. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Most staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. On the day of the inspection certificates for basic life support were not available. However we were sent evidence that the GP's had undertaken basic life support on-line training after the inspection. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams. Clinical audits were undertaken but the practice did not have a system in place for ensuring completed clinical audit cycles were demonstrating improved patient outcomes.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was consistently and strongly positive. Data from the January 2015 national GP patient's survey said 93% of patients had confidence and trust in the last GP they saw and 94 % of patients had confidence in nurses. 83% felt the GP was good at listening and 87% for nurses. 74% said GP's treated them with care and concern and 84% for nurses. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff were motivated and inspired to offer kind and compassionate care and

Summary of findings

worked to overcome obstacles to achieve this. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patient's comments were mixed in relation to getting through by phone and availability of appointments. We saw evidence that the practice continued to look at both these issues. Feedback from patients reported that access to the same 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. A poster about how to complain was not available in the waiting room but evidence showed that the practice responded quickly to issues raised. We did not see any evidence that learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. We looked at a number of these policies and found that some were overdue for review, for example, the recruitment policy was due for review in March 2012. There was no clear policy for ensuring that medicines were kept at the required temperatures or the action to take in the event of a potential failure. We spoke with the management team who advised us that they would write a cold chain policy for staff to follow and use for guidance.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

The practice takes part in the Hippokrates Exchange Programme. It is an exchange programme for international and national medical doctors to gain experience of the work undertaken by doctors in general practice. Sleaford Medical Group are hosts to this programme and offers a broad perspective of general practice.

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.

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

87.9% of eligible patients had a care plan in place to avoid an unplanned admission to hospital.

68% of patients who had polypharmacy had received a medication review in the last 12 months.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 57.3% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had also identified the smoking status of 92.8% of eligible patients over the age of 16. There was limited evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was only 0.84%.

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. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met.

96.3% of patient with diabetes, 94.8% of patients with COPD and 78% of patients with Asthma had received a medication review. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

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. Immunisation rates were relatively high for all standard childhood immunisations. There were two immunisation clinics each week. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Midwives ran clinics three mornings a week. The practice had an 81% uptake for cervical screening

One of the reception staff that we spoke with was also responsible for tracking pregnancy and birth of children. This meant that births that were not registered with the practice within 4 weeks would receive a follow up letter asking them to do so. The practice would then invite the new babies into the practice and arrange vaccinations.

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 had extended hours on Tuesday, Wednesday and Thursday to enable patients who could not attend the practice during working hours to access a GP. 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 homeless people, travellers and those with a learning disability. The practice had just signed up to the enhanced service for learning disabilities and were in the process of commencing learning disability reviews.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable

Summary of findings

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).

Patients with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. 89.5% of patients with dementia had their care plan reviewed in the last year. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions.

95.4% of patients on the mental health register had received a mental health review. 92.7% of patients who suffered with depression had received a review.

The practice uses both the SystmOne dementia screening tool and the CANTAB tool. The tool gives GP practices the opportunity to offer their patients a screening test which can identify a potential cognitive impairment, helping to detect the earliest signs of clinically-relevant memory problems and enabling patients to receive the best care possible.

The practice regularly worked with multi-disciplinary teams in the case management of people 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 including MIND. MIND is a mental health charity in England and Wales. MIND offers information and advice to people with mental health problems.

Summary of findings

What people who use the service say

Prior to the inspection we spoke with staff from five care homes where patients who were registered with Sleaford Medical Group lived. They felt there had been a definite improvement at the surgery in terms of continuity with the GP's who visited the homes. Reception staff were mostly friendly and they had good relationships with the practice. The only negative comments related to getting through by telephone.

During the inspection we spoke with 17 patients. Patients told us that getting through by telephone to make appointments was a lot better and staff were helpful and caring. They were happy with the treatment and explanations and were treated with respect. They were not happy about not being able to see the same GP and had issues with parking at the surgery.

We also reviewed 32 comments cards that had been completed and left in a CQC comments box. The comment cards enabled patients to express their views on the care and treatment received. 24 comments cards were positive and patients felt they were treated with kindness, respect and compassion. All GP's and staff were helpful, good at listening and were courteous and efficient. Eight were less positive. The main concerns were not seeing the same GP, getting through by phone and not getting seen at their appointment time.

Patients said the practice was clean and hygienic. They said the waiting room was a decent size but could become hot when full. They told us that they received the right care and treatment and felt listened to. Staff respected their dignity.

We spoke with three members of the patient participation group (PPG). The PPG met bi-monthly and included representatives from various population groups, older people, recently retired, working people and mums. The PPG were enthusiastic about improving and working with the practice to improve services now and in the future.

In the January 2015 national GP patient survey 68% patients described the overall experience as good. 93% had confidence or trust in the last GP they spoke with 94% for the nurse. 70% said the GP involved them in decisions about care with 78% for the nurse.

The practice had commenced the Family and Friends testing (FFT) in September 2014 but had not done any analysis of the information received. FFT will enable patients to provide feedback on the care and treatment provided by the practice.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

The provider should :-

- Ensure clinical audits are completed cycles to demonstrate improvements to patient outcomes.
- Ensure all staff have access to policies, procedures and guidance which are robust, reviewed and updated to enable them to carry out their role, for example, cold chain, infection prevention and control, legionella and COSHH.
- Have appropriate systems in place to ensure standards of cleanliness are maintained and to prevent the risks of infection by; having cleaning schedules in place, finalising the legionella risk assessment and continuing to address infection prevention and control issues (such as cleaning the ear syringing equipment in line with the practice policy.)
- Have a risk assessment in place to ensure the safe management of emergency
- medicines to be administered to patients on home visits.
- Ensure learning from complaints is shared with all staff.
- PPG minutes should be available in the practice and on the practice website.
- The practice should have practice meetings which are regular, structured and relevant to give all staff the opportunity to take part, where information is shared

and lessons learnt. For example, significant events, complaints, risk management, infection control and NICE guidance. Meetings should be minuted in order to record summaries of topics discussed and actions to be taken.

Outstanding practice

- The practice had identified the need for more reception staff, health care assistants and minor illness nurses and had recently employed these staff. They had also created a new role within the minor illness unit to accommodate specific minor illness home visits with a view to increased capacity for GP's. In order to facilitate this the practice had proactively employed a triage and minor illness nurse trainer on a three year contract. This was in order to train and provide on-going support to a combination of nine existing or newly employed practice nurses in triage and minor illness.

Sleaford Medical Group

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, CQC inspection manager, a further three CQC Inspectors, CQC Pharmacist, a GP practice manager and an Expert by Experience.

Background to Sleaford Medical Group

Sleaford Medical Group provides primary medical services to approximately 18,250 patients. It covers Sleaford and surrounding villages. The practice has a dispensary which dispenses medicines to patients registered with the practice.

At the time of our inspection the practice employed four partners (three male, one female), two salaried GP's (one male and one female), one locum GP, one HR & Business Administrator,

one triage nurse consultant, six minor illness nurses, six health care assistants, two reception supervisors, 11 medical receptionists, one dispensary manager, four dispensers, three dispensary assistants, one locum dispenser, 15 administration and data quality staff.

The practice has a General Medical Services Contract (GMS). The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice has one location registered with the Care Quality Commission (CQC) which is Sleaford Medical Group, 47 Boston Road, Sleaford, Lincs. NG34 7HD.

Sleaford Medical Group is open from 8.30 to 6.30pm. Appointments were available from 8.40am to 11.10am and 3.40pm to 5.50pm on weekdays. Appointments were available with a GP registrar. GP registrars are fully qualified doctors who work under close supervision of the GP's within the practice.

On the day appointments were available for the minor injuries unit (MIU). The MIU is open from 8.30am until 6.30pm. The service is provided by practice nurses who have skills and experience in dealing with minor accidents or injuries which have occurred within 48 hours. The practice's extended opening hours on Tuesday, Wednesday and Thursday were particularly useful to patients with work commitments.

The practice is located within the area covered by NHS SouthWest Lincolnshire Clinical Commissioning Group (SWLCCG). The CCG is responsible for commissioning services from the practice. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

NHS South West Lincolnshire Clinical Commissioning Group (SWLCCG) is responsible for improving the health of and the commissioning of health services for 128,000 people registered with 19 GP member practices and the surrounding villages.

The practice was last inspected by the Care Quality Commission in August 2014, when it was judged to be in breach of Regulation 10 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The practice did not have in place effective systems to monitor the quality of the service provided. This related to a failure to assess and monitor the number of phone calls abandoned due to the phone line being engaged. There was a lack of audits to identify themes and trends for prescribing and dispensing errors.

Detailed findings

Sleaford Medical Group is a host practice for the Sleaford Neighbourhood Team. It is a new way of working across health and social care organisations launched across Sleaford and Grantham. They bring together health and social care professionals including GPs, community nurses, social workers, community psychiatric nurses and therapists. Integrated care aims to 'join-up' health and social care to meet the needs of an ageing population and transform the way that care is provided for people with long-term conditions, by enabling those with complex needs to lead healthier, fulfilling and independent lives.

Sleaford Medical Group has a Minor Injuries Unit which opens 8am to 8.00pm daily. The service is provided by practice nurses who have skills and experience in dealing with minor accidents and emergencies which have happened within 48 hours.

Sleaford Medical Group also provides an urgent care service at weekends and Bank Holidays which opens from 8.00am to 8.00pm. It caters for a population of 53,000 people. On arrival, patients are assessed and the injury treated by a trained nurse or doctor as appropriate. However in some cases it may be necessary to refer patients on to further treatment at a hospital. This service is available to patients whether or not they are registered with a GP, and can provide care for those not living in Sleaford or the surrounding area. The unit can care for patients attending with both minor illnesses and injuries and is a walk in service. The patients' own GP will receive a summary of the care received following the consultation so their notes can be updated accordingly. Any patient who cannot be treated will be referred as appropriate.

The practice had a website which we found had an easy layout for patients to use. It enabled patients to find out a wealth of information about the healthcare services provided by the practice. Information on the website could be translated in many different languages by changing the language spoken. This enabled patients from eastern Europe to read the information provided by the practice.

We inspected the following location where regulated activities are provided:-

Sleaford Medical Group, Riverside Surgery,47 Boston Road,Sleaford,Lincs.NG34 7HD

Sleaford Medical Group had opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided by Lincolnshire Community Health Services NHS Trust.

We spoke with the management team with regard to their registration certificate. There had been changes to the GP partners which was not reflected on their current certificate and did not fulfil the criteria in the CQC (Registration) Regulations 2009. After the inspection we received information that the registered manager had begun the CQC process to update their registration certificate.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had previously been inspected in August 2014 and before the CQC's new methodology. They were in breach of regulations so we have re-inspected to check that improvements have been made.

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed information from SouthWest Lincolnshire Clinical Commissioning Group (CCG), NHS England (NHSE), Public Health England (PHE), Healthwatch and NHS Choices.

Prior to the inspection we spoke with staff at five care homes where patients who were registered with Sleaford Medical Group lived. They felt there had been a definite improvement at the surgery in terms of continuity with the GP's who visited the homes. Reception staff were mostly friendly and they had good relationships with the practice. The only negative comments related to getting through by telephone.

We carried out an announced inspection on 6 May 2015.

We asked the practice to put out a box and comment cards in reception where patients and members of the public could share their views and experiences.

During the inspection we spoke with 17 patients. Patients told us that getting through to the practice by telephone to make an appointment was a lot better and staff were helpful and caring. They were happy with the treatment and explanations and were treated with respect. They were not happy about not being able to see the same GP and had issues with parking at the surgery. We reviewed 32 completed comment cards where patients had shared their views and experiences of the service.

During our inspection we spoke with three patients who were members of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We spoke with 25 members of staff which included two GP's, one HR and business administrator, one triage nurse trainer, three nurses, four health care assistants, two reception supervisors, three receptionists, four administrative staff, one secretary, one dispensary manager, one dispenser and two GP trainees.

We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, when a staff member had a needlestick injury.

We reviewed safety records, and incident reports. They demonstrated that the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of eight significant events that had occurred during the last year and we were able to review these.

Significant events were not a standing item on the practice meeting agenda but a dedicated meeting was held monthly to review actions from past significant events and complaints.

There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a timely manner. However the practice did not always fully complete the outcome. We saw evidence of the actions. The practice did not review significant events annually to detect themes or trends.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received relevant role specific training on safeguarding. We were sent evidence that the training was completed after the inspection. We asked members of nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were not easily accessible however all staff said that they would be able to access them if needed. The practice had a draft safeguarding policy which needed further work to ensure that if was specific to the practice.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. After the inspection we received certificates to demonstrate they had the necessary training to enable them to fulfil this role. Staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example a flag to identify that there were safeguarding concerns and this patient was under the care of the Safeguarding Lead.

There was a chaperone policy and signs were prominent in the waiting room area. However the consulting rooms did not have visible chaperone signs. We spoke with a member of staff who told us that all GPs offered a chaperone. We also spoke with a GP who always has a chaperone for female patients that require an examination. Male patients are also offered a chaperone. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. However not all reception staff had undertaken training but the business manager was in the process of

organising the training. The staff that we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was no clear policy for ensuring that medicines were kept at the required temperatures or the action to take in the event of a potential failure. We spoke with the management team who advised us that they would write a cold chain policy for staff to follow and use for guidance.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The dispensary had documents which they referred to as Standard Operating Procedures (SOP). All staff involved in the procedure had signed the SOP's to say they have read and understood the SOP and agree to act in accordance with its requirements. Standard Operating Procedures (SOP's) cover all aspects of work undertaken in the dispensary. The SOP's consisted of step-by-step information on how to execute a task and an existing SOP be modified and updated when appropriate. Such SOPs satisfy the requirements of the Dispensary Services Quality Scheme (DSQS). SOPs also provide a basis for training and assessment of competence.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of the directions and evidence that nurses had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring by the practice in line with national guidance. Appropriate action was taken based on the results. The IT system would highlight to staff if a patient was due for review. If review required high risk medicines would not be dispensed until a review had taken place.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training, appraisal and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed prescriptions at five remote locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Good

Are services safe?

The practice had undertaken an audit to monitor the turnaround times for repeat prescriptions and 99% of prescriptions were ready within 48 hours for patients to collect.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place for treatment rooms and cleaning records were kept. Staff working in these areas were able to demonstrate how they kept these areas clean and hygienic and where this was recorded. Nursing and Health Care Assistants were well-organised and had systems in place to clean on a monthly and daily basis and records were kept. There were no cleaning schedules for other areas. Any issues were raised directly with the cleaner. The practice were in the process of agreeing schedules with the cleaning company. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a new lead for infection control. He told us he planned to work with a recently appointed nurse who was experienced in infection control and who would be able to assist with advice and staff training. All staff received induction training about infection control specific to their role and received annual updates. The practice had recently employed an external company to carry out a thorough infection control audit. This resulted in an action plan. The practice had identified staff responsible for ensuring the actions were carried out within reasonable timescales and needed to continue to address the identified concerns.

The practice had a new draft infection control policy which was accepted in principle by the practice management. Despite this being a new policy we observed that staff used personal protective equipment including disposable gloves, aprons and coverings when treating patients. Information was displayed about what action to take in the event of a needle stick injury and staff were clear about the procedure to follow in the event of injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Sharps bins were correctly assembled and labelled. However not all staff were aware that sharps bins should be disposed of at three months whether full or not.

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use. We looked at the COSHH Policy and found that it was not comprehensive. The policy did not give guidance and support in order that staff and other people who may be affected by exposure to these substances were protected.

We saw that samples, for example, blood or urine, were put in a lined container by the patient's and kept in reception ready to be sent to the pathology laboratory for analysis. They were not touched by reception staff.

The practice had a draft policy for the management, testing and investigation of legionella (a bacterium that can ruin contaminated water and can be potentially fatal) and was in the process of arranging a risk assessment. After the inspection we were sent evidence that the practice had arranged an external company to carry out a legionella risk assessment on 18 June 2015.

There were arrangements in place for the safe disposal of clinical waste. Staff were clear about hazardous waste disposal. Yellow bins were kept locked and within the practice building.

Minutes of practice meetings we looked at did not show that the findings of any audits were discussed.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices. We saw a machine used for ear syringing had not be checked and cleaned in line with the practice procedure. We spoke with the management team who assured us that this would be immediately dealt with.

Staffing and recruitment

We looked at eight staff files. The human resources and business administrator had identified some gaps in staff files and was in the process of updating them. On the whole, the records we viewed contained evidence that appropriate recruitment checks had been undertaken prior

to employment. For example, photographic proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This had been due for review in 2012 and the human resources and business administrator told us this was being done alongside updating and streamlining the staff files.

The human resources and business administrator told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had identified the need for more reception staff, health care assistants and minor illness nurses and had recently employed these staff. They had also created a new role within the minor illness unit to accommodate some home visits carried out by the practice. In order to facilitate this the practice had proactively employed a triage and minor illness nurse trainer on a three year contract. This was in order to train and provide ongoing support to a combination of nine existing or newly employed practice nurses in triage and minor illness.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and a system to limit the number of staff able to take leave at the same time.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We did not see any evidence that any risks were discussed at GP partners' meetings and within team meetings

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. After the inspection the practice sent us evidence that the GP's had undertaken some basic life support training but could not show us that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. One staff member we spoke with described an incident when a patient had fainted at reception. The staff member pressed the panic button and two nurses and two GP's came very quickly to treat the patient. The patient was immediately taken through to the urgent care treatment room to receive treatment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. Hypoglycaemia is a low blood sugar.

A business continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had not yet carried out a fire risk assessment but we saw evidence that this was booked for the week

Good

Are services safe?

following our visit along with face to face fire training for all staff. After the inspection we received evidence that a full fire risk assessment and fire warden training had been carried out.

Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease, heart failure and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines, for example, for patients with Chronic Kidney Disease and COPD were being managed and informed treatment decisions made.

Our review of the clinical meeting minutes confirmed that this happened.

The electronic patient record enabled the administration staff to call patients for a review of their long term condition. Appointments were available and patients were encouraged to book an appointment if they attended the practice for another reason.

A GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had recently the overuse of a broad spectrum antibiotic called cephalosporin's. This issue had been addressed and the practice had no other areas identified as a problem.

Information from a practice visit report undertaken on 31 March 2015 by Commissioning Intelligence East Midlands Commissioning Support Unit showed that Sleaford Medical Group had a day case admission rate which was significantly lower than the CCG rate and that of Lincolnshire as a whole. Accident and Emergency attendance rates were significantly lower in comparison to Lincolnshire and the CCG. Emergency admissions were similar to the rest of the CCG but lower than Lincolnshire as a whole.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

National referral data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used the national standards for the referral of patients with suspected cancers for them to be referred and seen within two weeks. 2.87% of patients were referred and seen in line with the two week wait timeframe for suspected cancer in the last year.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98.3% of the total QOF target in 2014, which was 1.4% points above CCG Average and 4.8% above national average

For example:

- The performance for diabetes related indicators was 94.3% which was 0.9% better than the CCG and 4.2% better than the national average.
- The performance for asthma related indicators was 100% which was ,1.8% points above CCG average and 2.8% above the national average
- The performance for patients with hypertension was 99.2% which was 0.1% better than the CCG average and 10.8% better than the national average.

Good

Are services effective?

(for example, treatment is effective)

- The performance for patients with COPD was 100% and 3.6% better the CCG average and 4.8% better than the national average.
- The dementia diagnosis rate was 100% and. was 5.9% above CCG average, and 6.6 % above national average

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support.

We noted a good skill mix among the doctors. There were GP leads for long term conditions and two female GP's who provided comprehensive family planning services. The practice also provided minor surgery and joint injections. However the practice had struggled to recruit new suitably qualified GP's due to a national shortage. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Staff undertook appraisals that identified learning needs and included documented action plans. Appraisals for the current year had either taken place or were planned. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example a nurse we spoke with had recently completed cytology training after requesting this in order to extend her role.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines or cervical cytology. Those with extended roles such as treating minor illness or seeing patients with long term conditions such as diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

We spoke with the human resources and business administrator who described an example where poor performance had been identified appropriate action had been taken to manage this in line with the practice's disciplinary procedure which was also included in staff contracts.

The practice had identified the need for more reception staff, health care assistants and minor illness nurses and had recently employed these staff. They had also created a new role within the minor illness unit to accommodate some home visits carried out by the practice. In order to facilitate this the practice had proactively employed a triage and minor illness nurse trainer on a three year contract. This was in order to train and provide on-going support to a combination of nine existing or newly employed practice nurses in triage and minor illness.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post.

There was a system in place for staff to pass on, read and act on any issues arising from communications with other care providers on the day they were received. Post and blood tests results were scanned and sent to the GP with

whom the patient was registered. They were then responsible for any action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by community nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Sleaford Medical Group acts as a host practice for the Sleaford Neighbourhood Team. It is a new way of working across health and social care organisations launched across Sleaford and Grantham. They bring together health and social care professionals including GPs, community nurses, social workers, community psychiatric nurses and therapists. Integrated care aims to 'join-up' health and social care to meet the needs of an ageing population and transform the way that care is provided for people with long-term conditions, by enabling those with complex needs to lead healthier, fulfilling and independent lives.

The practice had patients who were registered with five nursing and care homes within the area. We spoke with staff from each home and the majority told us that the found the practice supportive. The GPs at the practice had a good relationship with the staff at the care homes. Three of the five care homes had regular visits from the GPs on set days each week. The continuity of care had improved recently with less locums attending and more involvement with the GP partners. Two other care homes told us they had no problems in requesting a home visit. However it did go through the triage process and at times they found it was difficult to get through to the practice on the telephone. This had improved over recent weeks. They all felt that overall there were continuous improvements being made at the practice in relation to the continuity of care and the telephone system. All five nursing and care homes felt the reception staff were generally friendly and helpful. However there had been occasions when the reception staff were not as helpful which they felt may have been due to the busy environment the receptionists worked in.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. 89.5% of patients with dementia had their care plan reviewed in the last year. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions.

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

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check, usually with one of the nurses, to all new patients registering with the practice in order to screen for disorders such as high blood pressure and diabetes. The GP was informed of all health concerns detected and these were followed up in a timely way.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 57.3% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help.

For example,

- 59.2% of eligible patients had received an influenza vaccination.
- 95.4% of patients on the mental health register had received a mental health review and 89.5% on the dementia register had received a dementia review.
- 92.7% of patients who suffered with depression had received a review.

The practice kept a register of all patients with a learning disability. They had just signed up for the enhanced service for learning disabilities and were in the process of commencing learning disability reviews.

87.9% of eligible patients had a care plan in place to avoid an unplanned admission to hospital.

68% of patients who had polypharmacy had received a medication review in the last 12 months.

The practice had also identified the smoking status of 92.8% of eligible patients over the age of 16. Of these patients, 99.0% had been given smoking advice. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 0.84%.

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

The practice's performance for cervical smear uptake was 81.3%. The administration staff contacted patients who did not attend for cervical smears. The practice sent a fourth reminder on pink note paper in an attempt to get the patients to attend for an appointment. Information from a practice visit report undertaken on 31 March 2015 by Commissioning Intelligence East Midlands Commissioning Support Unit showed that the practice had a higher screening rate for Chlamydia at 9.4% than the rest of Lincolnshire and slightly above average for the CCG.

There was a range of information on display in the patient waiting room. This included a wide range of health promotion and prevention leaflets, for example, relating to Alzheimer's support, memory clinics, ovarian and prostate cancer.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was average for the CCG.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey and a survey undertaken by the practice's patient participation group (PPG).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 68% of patients who rated the practice as good.

The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them, 87% for nurses. 84% of respondents said the GP gave them enough time and 90% for nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff treated them with kindness, respect and compassion. They said staff treated them with dignity and respect. Eight comments were less positive in relation to continuity of care and waiting times for appointments. We also spoke with 17 patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains or material curtains were provided in most of the consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located in a room behind the reception desk and was shielded by glass partitions which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. There were two reception staff at the front desk on the day of the inspection and they were well spaced out to allow some privacy even when more than one patient was at the desk. 76% of patients who completed the January 2015 national gp patient survey felt the receptionists were helpful. There was a radio situated on the reception desk that was on softly, which again aided confidentiality. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a separate small area in the waiting room which was shielded from the public and near to the duty doctor's consulting room. This area also had a water machine. Staff we spoke with told us this was used for patients that needed extra confidentiality or if patients were visibly upset. We observed a patient that came in visibly distressed who was then taken to this area by the reception staff. This allowed the reception staff to provide support. A GP was on hand if the situation needed clinical input.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with their immediate line manager.

There was a clearly visible notice in the patient reception area which stated the practice's zero tolerance for abusive behaviour. Receptionists we spoke with told us that in the past they had referred to it and it had helped them diffuse potentially difficult situations. They were also able to explain ways to diffuse situations which involved abusive behaviour and felt able to manage these situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the January 2015 national patient survey showed 93% of practice respondents had confidence in the GP and nurse. 70% said the GP involved them in care decisions and 78% for nurses. 76% felt the GP was good at explaining treatment and results and 87% for nurses. Both these results were average compared to CCG.

Good

Are services caring?

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

Staff told us that translation services were available for patients who did not have English as a first language. They told us the practice did not have many non-English speaking patients. However they had various options they could use if needed, such as the practice web site that could be translated and would usually provide the information that was required. There was also a translation service that could be booked if needed for an appointment.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 74 % of respondents to the January 2015 national GP patient survey said they treated with care and concern.

Notices in the patient waiting room, on the three TV screens and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Staff we spoke with were able to give us examples of how this could be found. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. However there were no specific carer's information given or displayed within the practice waiting area. A health care assistant (HCA) that we spoke with explained the importance of identifying carers and who they cared for. This ensured support for both carer and their loved one. A staff member we spoke with told us this information was clearly documented within the patient and carers records.

Staff told us that if families had suffered bereavement, there was no specific contact with the family unless the GP knew the family. However if the bereaved family member contacted the practice they were prioritised for a GP to contact them and were offered an appointment at a flexible time to give 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

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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

Sleaford Medical Group has a Minor Injuries Unit which opens 8am to 8.00pm daily. The service is provided by practice nurses who have skills and experience in dealing with minor accidents and emergencies which have happened within 48 hours.

Sleaford Medical Group also provides an urgent care service at weekends and Bank Holidays which opens from 8.00am to 8.00pm. It caters for a population of 53,000 people. On arrival, patients are assessed and the injury treated by a trained nurse or doctor as appropriate. However in some cases it may be necessary to refer patients on to further treatment at a hospital. This service is available to patients whether or not they are registered with a GP, and can provide care for those not living in Sleaford or the surrounding area. The unit can care for patients attending with both minor illnesses and injuries and is a walk in service. The patients' own GP will receive a summary of the care received following the consultation so their notes can be updated accordingly. Any patient who cannot be treated will be referred as appropriate.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We spoke with the PPG who told us they had been to look at other practices in the area to look at ideas for equipment in the practice. They had then gone on to purchase the three screens in the waiting room that currently showed health promotion but could be adapted to include local support and more practice specific information. The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

The PPG were involved in looking at and analysing data from the patient surveys that had been actioned in the practice. The PPG set the agenda for their meetings which were held bi-monthly. Where possible they were attended by one GP from the practice. There were suggestions that other staff groups could be involved in the future.

The PPG were enthusiastic about improving and working with the practice to improve services now and in the future. We saw minutes from the last four meetings and the PPG members that we spoke with explained that there were plans to be able to add these to the internet in the future.

Tackling inequity and promoting equality

The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. There was stair access to the first floor. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The premises and services had been adapted to meet the needs of patient with disabilities. There was a wheelchair available in the entrance to the practice. Whilst the door to the practice was not yet electronic the main doors were. There was a sign at the main practice double doors asking patients who required assistance at the dispensary. Whilst at the practice we observed disabled patients arriving in electric wheelchairs who had no difficulty in gaining access to the surgery. The reception desk and the dispensary desk both had lower levels for people in wheelchairs. The waiting room was large enough to facilitate people in wheelchairs.

We saw that the waiting area was large enough to accommodate prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

A GP we spoke with explained that the doors to the consulting rooms were not able to fit the wide wheelchairs or electric scooters. However there was another consulting room that could be used if required. This had being used

Good

Are services responsive to people's needs?

(for example, to feedback?)

on several occasions, for example, for bariatric patients. There was a hearing loop system in the practice and patients that had visual impairments where assisted to a chair in the waiting room by reception staff.

The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

The practice actively supported patients who have been on long-term sick leave to return to work. Patients who required repeat sick notes were given appointments with the same GP for continuity. The staff that we spoke with said that the GP's encouraged patients who were fit for work to come back to see them to discuss options such as a phased return and light duties.

Access to the service

Sleaford Medical Group is open from 8.30 to 6.30pm. 68% of patients who completed the January 2015 national GP patient survey were satisfied with the surgery opening hours. Appointments were available from 8.40am to 11.10am and 3.40pm to 5.50pm on weekdays. 57% of patients who completed the January 2015 national GP patient survey described the overall experience of making an appointment as good.

Appointments were available with a GP registrar. GP registrars are fully qualified doctors who work under close supervision of the GP's within the practice.

On the day appointments were available for the minor injuries unit (MIU). The MIU is open from 8.30am until 6.30pm. The service is provided by practice nurses who have skills and experience in dealing with minor accidents or injuries which have occurred within 48 hours.

The practice's extended opening hours on Tuesday, Wednesday and Thursday were particularly useful to patients with work commitments.

46% of patients who completed the January 2015 national GP patient survey said it was easy to get through to the practice by phone. This was below the CCG average. We had mixed comments from patients we spoke with and comments cards we reviewed. Patients said there had been some improvement in the time it took to get through by phone. Some patients still felt the practice needed to make further improvements. We spoke to the management team who showed us evidence that the practice was taking seriously the frustrations felt by patients. The practice had carried out audits of incoming telephone calls and had increased the number of staff available to answer calls at the busiest times of the day.

The practice had installed a new telephone system – called 'MyCalls'. It aimed to improve the quality of customer service. The practice had a real time view of phone call activity. The system logged every call including missed and abandoned calls. The on-screen display highlighted a range of call activity, statistics and provided reports to help monitor and further improve performance. The HR and business manager oversaw the system on a daily basis. It was implemented in response to issues raised by patients who experienced difficulty getting through to the practice by phone.

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

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to five local care homes by a GP and to those patients who needed one.

Sleaford Medical Group has a Minor Injuries Unit which opens 8am to 8. pm daily. The service is provided by practice nurses who have skills and experience in dealing with minor accidents and emergencies which have happened within 48 hours.

Sleaford Medical Group also provides an urgent care service at weekends and Bank Holidays which opens from 8.00am to 8.00pm. Patients are assessed and the injury treated by a trained nurse or doctor as appropriate. However in some cases it may be necessary to refer patients on to further treatment at a hospital. This service is available to patients whether or not they are registered

Good

Are services responsive to people's needs?

(for example, to feedback?)

with a GP, and can provide care for those not living in Sleaford or the surrounding area. The unit can care for patients attending with both minor illnesses and injuries and is a walk in service.

Patients were generally satisfied with the appointments system. 93% of patients who took part in the January 2015 national GP patient survey said their appointment was convenient. However only 34% were able to their preferred GP which was below the CCG average.

Patients we spoke with on the day of the inspection and comments card we reviewed confirmed that they could see a doctor on the same day if they needed to. They also said that they would prefer to see the same GP but had to wait at least two weeks to see the doctor of their choice. Information from a practice visit report undertaken on 31 March 2015 by Commissioning Intelligence East Midlands Commissioning Support Unit showed that 55% of patients saw or spoke to a GP or nurse on the same day which was above the CCG and national average.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they had rang the practice that morning, had spoken to the duty doctor and were seen by a GP within two hours.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. It had a written procedure 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 looked at the practice complaints procedure which was not detailed and did not give staff enough guidance on how to deal with complaints. Staff we spoke with could describe how they would advise a patient who wished to make a complaint or raise concerns.

We saw that information was available to help patients understand the complaints system. A leaflet described the practice complaints procedure and was available in the patient waiting area and on the practice website. Information available to patients gave guidelines on how to raise a complaint and what they could expect from the practice in response. It included details of advocacy support available for help with raising a complaint. Details for NHS England and the Health Service Ombudsman if the patient was not satisfied with the outcome of their complaint. The complaints leaflet given to patients needed updating to reflect the current structure within the practice and who was the complaints lead.

We looked at the last 12 written complaints received by the practice and found that they had been dealt with appropriately and responded to in a timely manner. The complaints had been investigated, reviewed and details of actions recorded in the complaints file. Patients were thanked for raising any concerns or complaints, and the response included an explanation and details of any action taken by the practice, for example, staff being reminded of responsibilities or changes in protocols etc. The response always included an apology.

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice did not review complaints annually to detect themes or trends. Lessons from complaints had not been shared with staff, however lessons learned from individual complaints had been acted on.

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 outcomes for patients. We spoke with two GP partners. Their vision is to always provide outstanding care for every individual patient registered with the practice. Their long term vision for the practice was to create a multi-disciplinary training facility for all forms of work within the health and social care sector with the emphasis on primary medical services.

The practice had identified the need for more reception staff, health care assistants and minor illness nurses and had recently employed these staff. They had also created a new role within the minor illness unit to accommodate some home visits carried out by the practice. In order to facilitate this the practice had proactively employed a triage and minor illness nurse trainer on a three year contract. This was in order to train and provide on-going support to a combination of nine existing or newly employed practice nurses in triage and minor illness.

We spoke with 25 members of staff and some knew the vision and what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and found that some were overdue for review, for example, the recruitment policy was due for review in March 2012. There was no clear policy for ensuring that medicines were kept at the required temperatures or the action to take in the event of a potential failure. We spoke with the management team who advised us that they would write a cold chain policy for staff to follow and use for guidance.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 25 members of staff and most were all clear about their own roles and responsibilities. Most felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We were not shown any evidence that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice undertook clinical audits but did not have a system in place for completing the cycle.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. We did not see any evidence that any risks were discussed at GP partners' meetings and within team meetings

Leadership, openness and transparency

Sleaford Medical Group used a new tool called MeetingSphere to support any meetings held in the practice. MeetingSphere provides an initial set of templates for getting started. A lead GP could assign colleagues as attendees to the meetings. They can then read minutes or agenda's on file, take over and run that session on behalf of the GP. We were told by a GP partner that this tool is used for face-to-face meetings but it could be used online if one partner is not in attendance in the practice. We were told this tool enabled the GP partners to informally share knowledge, add to agendas, log ideas for discussion and keep up to date records of areas discussed.

We did not see any evidence that team meetings were held regularly, at least monthly. However staff we spoke with told us team meetings were held every three months.

Staff told us that there was now an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Since the new HR and business manager had taken over there had been a great deal of enthusiasm and energy and they were all pulling together as a team.

The human resources and business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary

Are services well-led?

Good

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

procedures, maternity policy and management of sickness which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality, dignity at work and bereavement. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice encouraged feedback via their website, family and friends tests, national GP survey and NHS choices. The practice had gathered feedback from patients through audits of minor injuries, urgent care unit and telephone system. We looked at feedback for the urgent care unit. 44 patients were happy to use the service again and extremely likely to recommend it to family and friends.

We looked at the analysis of the Family and Friends Test for the past five months. 44% were extremely likely to recommend and 28 were likely to recommend the practice to family and friends. Positive comments included reception staff being helpful, doctors were good and the nurses were fabulous. Negative comments included a preference to see their own GP and at times the time for the phone to be answered was slow.

The practice had carried out a survey in December 2014. The practice manager showed us the analysis and actions which were considered in conjunction with the PPG. However the results and actions agreed from these surveys were not readily available on the practice website or in the practice waiting room.

The practice had an active patient participation group (PPG) with members that had sat on the group for a number of years. The PPG included representatives from various population groups, Older people, recently retired, working people and parents. The PPG met bi-monthly. The PPG had identified priority areas, for example, access for patients by telephone. Actions had already been taken by practice are already in place, for example, call monitoring system in reception to assess how many patients are waiting.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One staff member told us that they had suggested that the registration form for patients be re-designed and had requested that they would like to do this. The staff member had redesigned the form which was now in use. Another staff member that we spoke with said that they had suggested a change to the rota to enable more patients to be seen and not kept waiting. This had also been put into place and was working well. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us they felt very involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff. Staff knew how to raise and issue but were not aware of who to go to outside the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at eight staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was an approved training practice for doctors who wished to enter general practice. They are fully qualified doctors who work under close supervision from experienced GP trainers in the practice.

The practice had completed reviews of significant events and other incidents, for example, to commence a log for all drugs contained within the cardiac arrest trolley. We saw evidence where the reviews were shared with staff to ensure the practice improved outcomes for patients.