St Johns Medical Centre

Quality Report

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

Ratings

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

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 St John's Medical Centre on the 14 July 2016. Overall the practice is rated as inadequate. .

The purpose of this inspection was to ensure that sufficient improvement had been made following the practice being placed in to special measures as a result of the findings at our inspection on 29th September 2015 when we found the practice to be inadequate overall.

Following the most recent inspection we found that overall the practice was still rated as inadequate and although some progress had been made, further improvements were required. The ratings for providing an effective service had improved from being inadequate to requiring improvement. The rating for providing a safe and well led service remained inadequate.

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

- The practice had a governance framework in place but the associated systems and processes did not support the delivery of their strategy.
- Although the partners were positive about future plans we found that the practice was unable to demonstrate strong leadership in respect of safety.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. However, the system still required improvement to ensure reviews and investigations were thorough, learning disseminated and identified actions implemented to improve safety.
- Most risks to patients were now assessed and identified actions implemented.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a number of policies and procedures to govern activity, but some were overdue a review.

The areas where the provider must make improvements are:

- Ensure effective processes are in place for reporting, recording, acting on and monitoring significant events, incidents, near misses and complaints in order that action is taken to remedy the situation, prevent further occurrence and improvements are made as a result.
- Ensure the safeguarding system in place is effective and protects service users from abuse and improper treatment.
- Protect the health and safety of patients who are prescribed high risk medicines.
- Put an effective system in place for the recall of patients with long term conditions.
- Clarify key roles and responsibilities within the management team.

In addition the provider should:

- Ensure safety alerts are dealt with in line with the practice protocol.
- Undertake actions identified from the audit of infection control.
- Carry out clinical re-audits to ensure improvements have been achieved.
- Continue to embed the system for the identification of carers.
- Review themes and trends from complaints received.
- Formalise the process in place for the summarisation of paper patient records.
- Complete the patient survey, disseminate information to patients and staff and formulate an action plan if required.

This service was placed in special measures on 21 January 2016. Insufficient improvements have been made such that there remains a rating of inadequate for being safe and well led. Therefore the practice will remain in special measures and kept under review. Another inspection will be conducted within six months to ensure the required improvements have been made. If the required improvements have not been made we will take action in line with our enforcement procedures.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- There was a more open approach to reporting significant events but improvements were still required to ensure reviews and investigations were thorough, learning disseminated and identified actions implemented in order to improve safety.
- Since the last inspection the practice had put a system in place to safeguard adults and children from abuse. However further improvements were still required in relation to referrals from external agencies where actions were required.
- The management of high risk drug prescribing required improvement
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, infection control, legionella, display screen equipment and electrical fixed wire testing.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Further clinical audits had taken place but there was still no evidence that audit was driving improvement in patient outcomes.
- There was evidence of appraisals for most staff.
- The practice now had a process to monitor training. It took into account when training had taken place but not when it was overdue. For example, some GPs and nurses had still not completed the relevant safeguarding training.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with

Summary of findings

compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

- Patients completed CQC comment cards to tell us what they thought about the practice. We received 68 comment cards, 56 of which were all overwhelmingly positive about the standard of care received. A further 10 were positive about the standard of care but also had negative comments in regard to getting an appointment. Two patients were negative as they felt they had not been listened to. Comments cards we reviewed told us that the service was excellent. They were treated by professionals with compassion and understanding. Staff were caring and helpful and treated patients with dignity and respect.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The care co-ordinator had active links with the Lincolnshire Carers and Young Carers partnership and they had provided Carers awareness training. Two members of staff volunteered to be Carers Champions and the practice were in the process of working towards the Lincolnshire Carers Quality Award.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example, urgent access appointments were available. Home visits were available for older patients or patients who would benefit from these. Extended hours were available on Tuesday evening and a Saturday morning.
- Results from the January 2016 national patient survey showed that patients' satisfaction with how they could access care and treatment was above average in comparison to local and national averages. Comments cards we reviewed also told us that most patients were able to get appointments when they needed them.
- Longer appointments were also available for older patients, those experiencing poor mental health, patients with substance misuse and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a number of local care homes as required and to those patients who needed one.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had recently undergone some alterations to the reception and waiting area. This included an area which could be used if patients wanted a private area to talk to reception staff.
- The practice were taking part in a pilot for a local teledermatology service in conjunction with the SouthWest Lincolnshire Clinical Commissioning Group. This pilot enabled the GPs to photograph skin lesions and send the images securely to a Consultant Dermatologist to diagnose whether further treatment was necessary or not. This, in most cases, saved patients a journey to hospital.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. However themes and trends had not been identified and learning from complaints was not always shared with staff.

Are services well-led?

Inadequate

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

- Since the last inspection the practice had updated its CQC registration certificate. They were now in the process of adding two further GP partners to the certificate.
- Since our inspection in September 2015 we found that some improvements had been made but some areas still required further work. We found on-going breaches of some regulations.
- Although the partners were positive about future plans we found that the practice was unable to demonstrate strong leadership in respect of safety.
- The practice had a governance framework in place but the associated systems and processes did not support the delivery of their strategy.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. For example, nurse protocols.
- Meetings were held but the minutes required more detail to identify what had taken place and responsibilities and timeframes for actions identified.
- The practice was in the process of seeking feedback from patients and had recently formed a patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

The provider was rated as good for being caring and responsive, requires improvement for providing an effective service and inadequate for providing a safe and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However we also saw examples of good practice:

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- All patients over 75 have a named GP.
- The practice had a care co-ordinator who provided support to patients at risk of an unplanned hospital admission and losing their independence. They worked with multi-disciplinary teams, for example social services, the Neighbourhood team and Lincolnshire Well-being service to support the care of older people. They had completed care plans for 3.2% of patients who had been assessed as being at risk which was above the required 2%.
- The practice was responsive to the needs of older people, and offered home visits to care homes, patients who were housebound and urgent appointments for those with enhanced needs.
- Patients who were on the admission avoidance register had an alert on their patient record to inform all staff.

People with long term conditions

Inadequate

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

The provider was rated as good for being caring and responsive, requires improvement for providing an effective service and inadequate for providing a safe and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However we also saw examples of good practice:

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 93% which was 0.7% above the CCG average and 1.6% above the national average. Exception reporting was 5.5% which was 0.3% above CCG average and 0.3% above national average.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma was 82.7% which was 4.7% above the CCG average and 7.4% above the national average. Exception reporting was 1.4% which was 4% below the CCG average and 6.1% below national average.
- 89% of patients on four medicines or more had received a medication review.
- Longer appointments and home visits were available when needed.

Families, children and young people

Inadequate

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

The provider was rated as good for being caring and responsive, requires improvement for providing an effective service and inadequate for providing a safe and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However we also saw examples of good practice:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 87% to 92% and five year olds 85%. Reminder letters were sent out to children who were overdue their vaccinations. Information was also shared with the local health visitors.
- The practice's uptake for the cervical screening programme was 84% which was slightly higher than the CCG average of 82% and the national average of 82%.
- The practice had posters and leaflets for sexual health and self-testing for chlamydia in for 16-25 year olds.

Summary of findings

- We saw positive examples of joint working with health visitors. However the community midwifery team had not been invited to join the safeguarding meetings. On the day of the inspection the registered manager told us they would invite them to the next meeting.

Working age people (including those recently retired and students)

Inadequate

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

The provider was rated as good for being caring and responsive, requires improvement for providing an effective service and inadequate for providing a safe and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However we also saw examples of good practice:

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Patients aged 40-74 were offered NHS Healthchecks.
- The practice offered extended access on a Tuesday evening from 6.30pm to 8.30pm and Saturday morning from 9.30am to12 noon for working patients who could not attend during normal opening hours.

People whose circumstances may make them vulnerable

Inadequate

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

The provider was rated as good for being caring and responsive, requires improvement for providing an effective service and inadequate for providing a safe and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However we also saw examples of good practice:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The care co-ordinator undertook regular reviews of patients who are vulnerable.

Summary of findings

- 54% of patients with a learning disability had a care plan in place. The practice had sent out further letters to all those who had not attended the surgery and two more patients had responded and would have visits from the care co-ordinator in order for a care plan to be put in place.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. For example, it had an in house substance misuse service in partnership with the Drug and Alcohol Recovery Team (DART) four days a week.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children.

People experiencing poor mental health (including people with dementia)

Inadequate

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

The provider was rated as good for being caring and responsive, requires improvement for providing an effective service and inadequate for providing a safe and well led service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However we also saw examples of good practice:

- 95% of patients diagnosed with dementia had a care plan in place.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 96.7% which was 7.6% above the CCG average and 12.7% above the national average. Exception reporting was 3.2% which was 4.1% below the CCG average and 5.1% below the national average.
- The dementia diagnosis rate was 73.9% which was 8% below the CCG average and 7.6% below the national average. Exception reporting was 8% which was 2.1% above the CCG average and 0.4% below national average.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. For example, the practice offered an in house counselling service and a psychiatrist attended the practice and ran a weekly clinic. The practice co-ordinator attended the admission avoidance meetings and supported the Grantham Volunteer dementia group.

Summary of findings

What people who use the service say

The national patient survey results were published on 7 January 2016. The results showed the practice was performing better in most areas compared to local and national averages. 252 survey forms were distributed and the practice had a return rate of 39%. This represented 1.7% of the practice's patient list.

- 79% find it easy to get through to this surgery by phone compared with a CCG average of 75% and a national average of 73%.
- 91% find the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 70% with a preferred GP usually get to see or speak to their preferred GP compared with a CCG average of 59% and a national average of 59%.
- 81% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86% and a national average of 85%.
- 89% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 75% describe their experience of making an appointment as good compared with a CCG average of 74% and a national average of 73%.
- 75% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 66% and a national average of 65%.
- 64% feel they don't normally have to wait too long to be seen compared with a CCG average of 60% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 68 comment cards, 56 of which were all overwhelmingly positive about the standard of care received. A further 10 were positive about the standard of care but also had negative comments in regard to getting an appointment. The remaining two comment cards reflected that the patients felt they had not been listened to. Comments cards we reviewed told us that the service was excellent. They were treated by professionals with compassion and understanding. Staff were caring and helpful and treated patients with dignity and respect.

Areas for improvement

Action the service MUST take to improve

- Ensure effective processes are in place for reporting, recording, acting on and monitoring significant events, incidents, near misses and complaints in order that action is taken to remedy the situation, prevent further occurrence and improvements are made as a result.
- Ensure the safeguarding system in place is effective and protects service users from abuse and improper treatment.
- Protect the health and safety of patients who are prescribed high risk medicines.
- Put an effective system in place for the recall of patients with long term conditions.
- Clarify key roles and responsibilities within the management team.

Action the service SHOULD take to improve

- Ensure safety alerts are dealt with in line with the practice protocol.
- Undertake actions identified from the audit of infection control.
- Carry out clinical re-audits to ensure improvements have been achieved.
- Continue to embed the system for the identification of carers.
- Review themes and trends from complaints received.
- Formalise the process in place for the summarisation of paper patient records.
- Complete the patient survey, disseminate information to patients and staff and formulate an action plan if required.

St Johns Medical Centre

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 specialist advisor , a second CQC Inspector and a GP practice manager specialist advisor

Background to St Johns Medical Centre

St Johns Medical Centre provides primary medical services to approximately 15,083 patients. This is above the NHS South West Lincolnshire Clinical Commissioning Group average of 6916 patients and national average of 7324 patients.

At the time of our inspection the practice employed six GP partners (three male, three female which equated to 6.25WTE), two salaried GPs (male), one practice manager, one deputy practice manager, one acting practice manager, three advanced nurse practitioners, one diabetic nurse specialist, one complex care co-ordinator, four practice nurses, three health care assistants, one reception manager, one deputy reception manager and reception and administration 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 St Johns Medical Centre, 62 London Road, Grantham, Lincs. NG31 6HR

Patients have telephone access to the practice from 8.00am to 6pm Monday to Friday. The practice doors open from 8.30am to 6.30pm Monday to Friday.

Appointments were from 8.50am to 10.40 am and 3.30pm to 5.40pm.

Extended hours appointments were offered on a Tuesday Evening from 6.30pm to 8pm and every Saturday from 8.50am to 11.30am.

Phone call consultations with a GP and urgent appointments with a nurse practitioner were available on the day for people that needed them.

Appointments could be booked on line for GPs and could be booked up to four weeks in advance.

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 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 by changing the language options. This enabled patients from eastern Europe to read the information provided by the practice.

Detailed findings

We inspected the following location where regulated activities are provided: - St Johns Medical Centre, 62 London Road, Grantham, Lincs. NG31 6HR

St John's Medical Centre 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.

On 29 September 2015 we had 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. At that inspection we found the practice inadequate overall but specifically the rating for providing a safe, effective and well led service was inadequate. As a result the practice was placed in to special measures for a period of six months from 21 January 2016. The practice were also issued with enforcement actions which provided a clear timeframe in which to improve the quality of care they provide. We carried out this further comprehensive inspection to ensure that sufficient improvement had been made in order for the practice to be taken out of special measures.

At our last inspection we also found the practice was registered incorrectly with the Care Quality Commission. Since then the provider had been taking the necessary action and was now registered correctly. The registered manager had completed all the relevant documentation to add two further GP partners to their registration. CQC had received all the documentation and were in the process of issuing a new registration certificate.

Why we carried out this inspection

On 29 September 2015 we had 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. That inspection was planned to check whether the provider was 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. At that inspection we found the practice inadequate overall but specifically the rating for providing a safe, effective and well led service was inadequate. As a result the practice was placed in special measures for a period of six months from 21 January 2016. We carried out this further comprehensive inspection to ensure that sufficient improvement had been made in order for the practice to be taken out of special measures.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 July 2016.

During our visit we:

- Spoke with a range of staff and spoke with one patient who used the service and was a patient participation group member.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

At the inspection in September 2015 we found that the practice did not have an effective system in place to ensure that incidents were recorded, investigated and reviewed in a consistent manner. It was not apparent that all staff were aware of their responsibilities to raise concerns, or knew how to report incidents and near misses.

At this most recent inspection we found that the system for recording, investigating and reviewing of significant events was still ineffective. We were sent six significant event forms to review before the inspection. On the day of the inspection we found that significant events had not been stored centrally and six more were found on the practice computer system and a further two were discussed at a practice meeting on 12 April 2016. This meant that the significant events were not kept in one place to ensure they were accessible to staff who needed them. No discussions were found for the significant events found on the computer system. We asked for the forms for the two discussed at the meeting on 12 April but they could not be found for us to see on the day of the inspection. For example, in respect of a wound infection and a medicine used to relieve neuropathic pain.

The practice had a significant event policy which had been reviewed on 8 July 2016. It stated that significant events would be reviewed on a monthly basis by the CQC registered manager and the practice manager. All incidents would be reviewed annually within a protected teaching practice afternoon. It also detailed that from August 2016 electronic copies of significant events would be stored on a new intranet documentation management system.

We looked at four significant event analyses in detail. We found that the recording and analysis of all four did not demonstrate a clear account of what had happened, was not in-depth and records of the actions taken were brief. For example, in regard to a disclosure of medical information to a third party occurred in March 2016 and was discussed at a practice meeting on 5 July 2016. The significant event form identified that information had not been given to the patient but a relative. The action was brief. No reference was made to the policy for giving out test results, had it been reviewed or whether the patient had received an apology.

Staff we spoke with told us that nursing staff would inform the nurse manager and non-clinical staff told would inform the practice manager of any incidents, and there was a recording form available. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

At the inspection in September 2015 we found that significant events were discussed regularly at practice meetings but the minutes did not demonstrate that any learning or improved outcomes for patients had taken place. At this most recent inspection we found that significant events were regularly discussed at practice meetings. However the minutes of the meetings were brief and did not specifically identify the discussion that had taken place. There was no evidence to support that learning and changes had been embedded within the practice. The actions did not provide sufficient detail to ensure learning and actions were effective, followed up or risks mitigated to prevent a similar event occurring in the future or to ensure the changes were effective and embedded within the practice. We did not see any evidence that the practice had undertaken a yearly review to identify themes and trends as set out in the practice policy.

At this inspection we found that the practice did not have a consistent system in place for receiving, discussing and monitoring of patient safety alerts. Staff told us they were disseminated by the practice manager. We saw limited evidence in meeting minutes to demonstrate that patient safety alerts were discussed to ensure that all relevant staff were aware of any necessary actions. There was no system for the storing of patient safety alerts for future reference. However since the inspection the practice have told us that the Safety alerts have been stored in an electronic Docman library for ease of access and future reference. The practice had a detailed safety alerts protocol to provide guidance to staff.

Overview of safety systems and processes

The practice had improved some of the systems, processes and practices in place to keep people safe but there were also areas identified where systems were still not well embedded.

Inadequate

Are services safe?

- At our inspection in September 2015 we found evidence that there were inadequate systems or processes in place to safeguard service users from abuse and improper treatment.
- At this inspection we found that the practice had changed their safeguarding lead. They had worked hard to implement systems and processes in regard to safeguarding. We found evidence that some safeguarding alerts for children and vulnerable adults were recorded on the electronic patient record. However we found that further improvements were required. For example, in respect of dealing with safeguarding referrals from external agencies such as East Midlands Ambulance Service. We found that a referral had been made in February 2016 and had still not been actioned. We also found letters of communication in regard to child protection on 14 April 2016 where a child had been discussed. We looked at the patient electronic record and found that the responsible person for this child had not been added as an alert as detailed within this letter.
- Staff we spoke with were able to tell us who the safeguarding lead was and demonstrated they understood their responsibilities. Staff were able to show us safeguarding information that was present in the treatment and consultation rooms. The practice had no system in place to evidence training that had occurred and no record of when updates were required. We found that some GPs had not trained to child safeguarding level 3 and some practice nurses were not trained to level 2.
- Policies were accessible to all staff. However the contact details contained within the policies for external agencies were limited. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies
- At our inspection in September 2015 we asked the lead GP for safeguarding about the process for the discussion of vulnerable adults and children. We were told the practice did not have a system in place and we found that no multi-disciplinary safeguarding meetings took place. We took enforcement action and the practice received a warning notice for Safeguarding service users from abuse and improper treatment, Regulation 13, of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. At this inspection we saw evidence that multi-disciplinary meetings had taken place and were minuted. However we found that the practice had not included the midwifery team so that concerns regarding an unborn child could be discussed. We found an example of a baby that had a child protection plan in place The safeguarding lead told us she would deal with this straightaway and invite the midwifery team to all future meetings.
- At the inspection in September 2015 we found that not 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). Neither was there a risk assessment in place to address this. At this inspection we found that all staff who undertook chaperone duties had received a DBS check and had been trained for the role. A notice in the waiting room and consulting rooms advised patients that chaperones were available if required.
- At the inspection in September 2015 we found that the practice did not have effective systems to ensure patients and staff were protected from the risk of infection. The infection control lead had not attended any training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw there was a cleaning schedule for the premises which had been provided by the cleaning company. However this was not detailed enough for specific areas of the practice, for example treatment rooms. The records seen were not comprehensive enough to provide assurance that individual rooms or areas had been cleaned. There were no formal records of any spot checks having taken place.
- At this inspection we observed the premises to be clean and tidy. The practice had done some refurbishment and made changes to the downstairs reception and waiting area and to a room on the first floor which had given them an extra clinical room. A practice nurse had attended training which now enabled them to provide advice on infection control. They now liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and most staff had received up to date training. We again looked at the cleaning schedule for the premises which had been provided by the cleaning

company. This was still not detailed enough for specific areas of the practice, for example treatment rooms. We were told spot checks of cleaning took place but there were still no formal records kept by the practice.

- At the inspection in September 2015 we found the practice had carried out an infection control audit of the rooms used by the practice nurses on 26 September 2015. Prior to this there was no evidence of any infection control audits having been carried out in order to identify any improvements required. The current audit had identified a number of areas which the practice needed to address. They practice had not had the opportunity to do this at the time of our inspection as the audit had been carried out three days before our visit. At this inspection we found that the infection control lead had done an infection control audit in June 2016. However it was not a complete audit as they had not audited all the rooms and areas in the practice in relation to infection control. We spoke with the lead who told us they would complete the remaining areas of practice and put together an action plan to address any improvements identified as a result. Since the inspection the lead has completed a full infection control audit of all areas of the practice. A number of actions have been identified but no action plan had been put in place to address these.
- Most of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).
- The prescribing lead told us they now used Optimise Rx, a computer support tool which advises GPs on the most appropriate, cost-effective medicines. It would also alert the GP if there are any contra-indications with medicines already taken by the patient.
- At this inspection we checked the system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. We found that the system did not protect the health and safety of patients on these high risk medicines... For example, we looked at a hospital letter and found that a patient on methotrexate was unable to take oral tablets. They received intramuscular injections for this high risk medicine. The practice had not added an alert to the patient record system to advise prescribers to the possible medicine interactions associated with this medicine. The prescribing lead took immediate action and added an alert to the patient's record. They also put an action plan in place to audit all patients on the Rheumatoid arthritis register within the next four weeks with a re-audit to follow in three months.
- At our inspection in September 2015 we found a lack of systems and processes in place to ensure fridge checks were recorded and being reset on a daily basis. At this inspection we checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We found that records showed fridge temperature checks were carried out on a daily basis and reset which ensured medication was stored at the appropriate temperature. The practice had had a significant event in regard to vaccines fridges and they had followed the cold chain policy. However we found on the day of the inspection that only two out of six fridges had data loggers to show when the temperature reached unacceptable levels. The information was not downloaded on a regular basis to ensure that the internal temperature of the fridges kept within the recommended guidance.
- At our inspection in September 2015 we found that the practice did not have a clear cold chain policy to provide guidance to staff or which detailed the process to ensure that medicines were kept at a regular temperature and described the action to take in the event of a potential failure.At this inspection we reviewed the June 2016 policy and procedure for maintaining the vaccine cold chain which provided staff with sufficient guidance on what action to take in the event of a break in the cold chain.
- At our inspection in September 2015 we found a lack of systems and processes in place to ensure pads for hand written prescriptions were tracked through the practice. At this inspection we found the practice had implemented a system to ensure both prescriptions and printer stationary were securely stored and there were systems in place to monitor their use.
- At the inspection in September 2015 we found that three members of the nursing staff were qualified as independent prescribers. We were told that they received regular informal supervision and support in

their role. However due to lack of time, training updates in the specific clinical areas of expertise for which they prescribed did not always take place. At this inspection evidence of any update training for nursing staff was not available but staff we spoke with told us that requested training was granted. Following the inspection evidence was sent in regard to the training updates for nursing staff.

- At the inspection in September 2015 we found that the practice did not have a system in place to ensure that the Patient group directions (PGD's) were signed by a GP and all relevant members of the nursing team. PGDs are specific written instructions for the supply or administration of a licensed named medicine including vaccines to specific groups of patients who may not be individually identified before presenting for treatment. At this inspection we found Patient Group Directions had been signed and adopted by the practice to allow nurses to administer medicines in line with legislation Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out fire drills. Most electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We looked at the defibrillator used in the event of an emergency situation. We found that it had not been checked and calibrated. Since this inspection the practice have provided us with evidence that this took place on 19 July 2016.
- There was no Electrical Installation Condition Report (EICR) available. Since the inspection the practice had sent us the EICR certificate. This had expired in February 2016. The practice have told us an electrical inspection was now planned for 30 July 2016.
- At the inspection in September 2015 we were shown a legionella testing certificate dated April 2015. However the practice did not have an on-going system, risk assessment or policy in place for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). At this inspection we found there was a legionella management policy in place. However we were told a risk assessment had been undertaken but it was not available on the day of inspection. Following this inspection the practice had contacted an external contractor who completed a full legionella risk assessment on 19 July 2016. They told us they would carry out the remedial work recommended by the first week of August 2016.
- The practice had other risk assessments in place to monitor safety of the premises such as a fire risk assessment and health and safety risk assessments. However, there was no risk assessment in place relating to the control of substances hazardous to health and infection control. Following the inspection we were sent risk assessments in respect of the control of substances hazardous to health.
- The acting practice manager told us they had completed a generic risk assessment for each staff group for display screen equipment (DSE). However staff had not completed an individual DSE checklist to ascertain if they required alterations to their workstations.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. However we were told that access and availability of appointments was not reviewed to take into account annual leave or bank holidays.

Arrangements to deal with emergencies and major incidents

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

Inadequate

Are services safe?

- At our inspection in September 2015 we found a there was not a clear system in place for checking emergency equipment and medicines including the doctors' bags. There were omissions in the records for the checking of emergency equipment and medicines. At this inspection we found that a system had been put in place.
- We checked the emergency equipment. The practice had a defibrillator available on the premises with both adult and paediatric defibrillator pads. Oxygen was also available with adult and children's masks. A first aid kit and accident book were available. We reviewed the equipment checklists and found that they had been checked
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.The practice had a business continuity plan in place for major incidents such as power failure or building damage. The emergency contact numbers for staff was sent after the inspection.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff was kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs.

We saw minutes of partner and clinical meetings held since the September 2015 inspection where NICE guidance was discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

The most recent published results for 2014/15 were 97.2% of the total number of points available, with 9% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients were unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for QOF (or other national) clinical targets. Data from 2014/15 showed;

For example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 93% which was 0.7% above the CCG average and 1.6% above the national average. Exception reporting was 5.5% which was 0.3% above CCG average and 0.3% above national average.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma was 82.7% which was 4.7% above the CCG average and 7.4% above the national average. Exception reporting was 1.4% which was 4% below the CCG average and 6.1% below national average.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 84.1% which was 1.9% below the CCG average and 0.5% above the national average. Exception reporting was 3% which was 0.9% below the CCG average and 0.8% below national average.
- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional was 91.3% which was 2.4% above the CCG average and 1.5% above the national average. Exception reporting was 2.8% which was 6% below the CCG average and 8.3% below national average.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 96.7% which was 7.6% above the CCG average and 12.7% above the national average. Exception reporting was 3.2% which was 4.1% below the CCG average and 5.1% below the national average.
- The dementia diagnosis rate was 73.9% which was 8% below the CCG average and 7.6% below the national average. Exception reporting was 8% which was 2.1% above the CCG average and 0.4% below national average.

The practice had a practice care co-ordinator. Their role included the completion of care plans for patients in nursing homes and those who have a learning disability or dementia. They also visited any patients who were housebound and unable to attend the practice.

In addition one of the health care assistants had been trained to use the CANTAB tool which gives a quick and accurate assessment of a patient's memory. The results were then be reviewed by the patient's named GP.

At the inspection in September 2015 we found that the practice did not have a clear system for the recall of patients for long term conditions and vaccination programmes. At this inspection the GPs demonstrated that the system of recall of long term conditions utilised the EMISweb QOF monitoring system alongside the process of repeat prescriptions. However we were still not assured that the system they had put in place was effective for the

Requires improvement

Are services effective?

(for example, treatment is effective)

recall of long term conditions. We were told that the practice had recently identified a member of staff to undertake the recall process. They had not commenced this role and had not received any training in relation to this

We spoke with a member of staff who had a clear system in place for the management of immunisations and vaccination programme. They described the monitoring processes they had in place and we saw that they reviewed and updated this on a regular basis. We also saw that there was information in the patient waiting areas and on the TV screen in reception.

At our inspection in September 2015 we found a lack of systems and processes in place to evidence quality improvement including completed clinical audit cycles.

- At this inspection we found that four clinical audits had been carried out since the last inspection. For example, in relation to chronic kidney disease (CKD). The audit found a need to identify and appropriately code patients with CKD and that NICE guidance was not currently being followed. There was no action plan but the proposed action was to devise a protocol and re-audit in a further six months We did not see any evidence of a discussion in meeting minutes or a protocol to provide guidance to staff.
- The diabetes audit was to identify patients with a raised blood sugar or blood test level who had not been diagnosed as a diabetic. The audit identified 48 patients who should have had their test results acted upon. As a result the GPs were asked to review all their patients identified as per the practice protocol and involve the diabetes nurse. A re-audit was planned for November 2016.We did not see any evidence of a discussion in meeting minutes and the protocol was not detailed enough to provide guidance to staff.
- The practice had an audit policy(review dated 14 June 2016) that stated that the operational lead is the practice manager who would ensure the sharing of audits with all staff members and clinicians with the practice by organising regular meetings in the practice once every three months.
- We spoke with the GPs who told us that there had not been enough time since the last inspection to complete any full audit cycles where the improvements made were implemented and monitored.
- The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or lower than other GP practices in the area. Up to June 2016 antibiotic prescribing for the practice was 0.88 which was a further reduction from 0.93 in June 2015. This was lower than the CCG average of 1.027 and CCG target of 1.161. The prescribing of cephalosporin's and quinolone rates for the practice was 8% which was lower that the CCG average of 11.5% and CCG target of 11.5%.
- At the inspection in September 2015 we found no system in place for palliative care monitoring and review. The practice had a register but we found no care plans in place, no scanning of DNAR records onto patient notes and formal palliative care meetings had not taken place since May 2015. We found that no information had been disseminated to staff within the practice. At this inspection we found that the practice now had a system in place for palliative care with regular monitoring, discussion and reviews evidenced in monthly meeting minutes. We also saw evidence that included alerts and the scanning on DNAR forms onto the patient record.

Effective staffing

At the inspection in September 2015 we found that the practice did not have a system in place to check the annual Nursing and Midwifery (NMC) or General Medical Council (GMC) status of registered nurses and general practitioners. On the day of this inspection there was still no evidence available that this was taking place. Following the inspection we were sent information that the practice manager had undertaken the yearly checks in June 2016.

At the inspection in September 2015 we found that the practice did not have a training matrix in place to identify when staff training was due. At this inspection we found there was a spread sheet available which recorded some details of staff training but there was still no system in place which identified when training was due. We were told by the acting practice manager that a more effective system would be incorporated in the new computer system being installed at the end of July 2016. This would provide the practice with an intranet system that has a central and accessible store for documents by all practice staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

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

- The practice had an induction programme for all newly appointed staff. Staff were booked on to training as soon as possible after starting and this would cover such topics as safeguarding, infection prevention and control, fire safety, health and safety and information governance.
- On the day of the inspection the practice were unable to demonstrate how they ensured role-specific updating training for relevant staff. For example, for those carrying out cervical smears. Following the inspection the practice provided us with information that updates for cervical smears and immunisations and vaccinations had taken place in 2015 and staff were booked to complete further updates in September and October 2016.
- The learning needs of most staff were identified through appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support, one-to-one meetings and facilitation and support for revalidating GPs.
- At the inspection in September 2015 we found that nursing and healthcare staff had not had an appraisal since 2013. At this inspection the non-clinical staff files we looked at contained evidence of an appraisal. However we were told that nursing staff had received appraisals in 2016 but only one was available to view. We were told the lead nurse held the others and they were not accessible as she was not available on that day. Since the inspection the practice have sent us further evidence which detailed that all the nurses had received an appraisal in 2016.
- At this inspection we asked to see the training for staff who ran the INR (regular International Normalized Ratio) clinics. In September 2015 we found that these clinics were run by a health care assistant (HCA) with support from the lead nurse. The HCA had received training in 2009 and not had any updates. Since 2015 the lead nurse had completed an oral anticoagulation update but the practice did not have any training evidence in relation to the HCA. Following this inspection the practice informed us that the HCA has been booked on an update on 19 October 2016.The lead nurse had an updated anticoagulation policy. However it was not specific to the practice and did not identify what service was provided by the practice, by whom or the training required.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. On line training had been introduced recently and staff had access to this and had started to make use of the e-learning training modules.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- At the inspection in September 2015 we found that the practice did not have a clear system for checking and acting on abnormal pathology results. At this inspection we found that the duty Dr was responsible to check and act on any pathology results received on that day. We checked a random sample and found that action had been taken and information regarding the action documented.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice used 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
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.
- The care co-ordinator had a good system in place to code and add alerts to the electronic patient record for

Requires improvement

Are services effective?

(for example, treatment is effective)

all patients who were on the unplanned admission caseload. We were told and we saw minutes of a monthly meeting where patients were discussed and an appropriate decision made on their future care.

- The care co-ordinator worked closely with the Neighbourhood Team (a CCG initiative) who identified those most at risk of health and social care problems. The team decide how best to manage their needs, with the patient being at the centre of that decision making process wherever possible. The team brought together local health and social care professionals from different specialties (who may have been looking after the same patient individually) into a single patient-focused team.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance.

- There was a practice policy for documenting consent for specific interventions.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Many of the staff had undertaken training in the Mental Capacity Act.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice also ran an Patients were signposted to the relevant service.
- The practice's uptake for the cervical screening programme was 84.46% which was slightly higher than the CCG average of 82% and the national average of 82%. The administration team identified patients who had not attended for cervical screening. Patients were contacted by phone or by letter. An alert was also put on the patient's electronic record to remind staff should the patient attend the practice. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 87% to 92% and five year olds 85%. Reminder letters were sent out to children who were overdue their vaccinations. Information was also shared with the local health visitors.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

Results from the January 2016 national patient survey showed a high level of satisfaction of patients with the practice. Patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 95% said the GP gave them enough time compared to the CCG average of 86% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%.
- 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

We received 68 comment cards, 56 of which were all overwhelmingly positive about the standard of care received. A further 10 were positive about the standard of care but also had negative comments in regard to getting an appointment. Comments cards we reviewed told us that the service was excellent. They were treated by professionals with compassion and understanding. Staff were caring and helpful and treated patients with dignity and respect.

We spoke with one member of the patient participation group (PPG). They also told us they were very well supported and listened to by the practice. They were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received told us they felt involved in decision making about the care and treatment they received. Most told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results slightly above local and national averages. For example:

- 90% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 85% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 82%.
- 90% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We also saw notices in the reception areas informing patients this service was available. Some were written in Polish.
- Information leaflets were available in easy read format.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.
- At the inspection in September 2015 we found that the practice did not have a system in place to identify if a patient was a carer or a consistent approach to ensure that carers were recorded and an alert set up on the patient electronic record. From 1998 only 81 patients had been identified as carers. Staff we spoke with told us this was not discussed when patients registered with the practice.
- At this most recent inspection we found that the practice had changed the registration process to include a question about carers. They had identified 118 patients as carers (0.78% of the practice list). The practice patient electronic record system had carer alerts in place to prompt staff to offer greater flexibility/ understanding when making appointments. The care co-ordinator had active links with the Lincolnshire Carers and Young Carers partnership and they had provided Carers awareness training. Two members of staff volunteered to be Carers Champions and the practice were in the process of working towards the Lincolnshire Carers Quality Award. We saw the practice newsletter for June 2016 which had information on carers, how to register and advised that flexible appointments were available. Written information was available to direct carers to the various avenues of support available to them.
- Staff told us that if families had suffered bereavement their usual GP sent them a sympathy card.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that that the practice had made patient needs and preferences central to its systems to ensure flexibility, choice and continuity of care. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example,

- The practice offer extended access evening on a Tuesday evening from 6.30pm to 8.30pm and Saturday morning 9.30am to 12 noon for working patients who could not attend during normal opening hours.
- Home visits were made to a number of care homes and were also available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- Full facilities were provided for patients with wheelchairs which included an easy access toilet, a low reception desk section and wide doorways.
- The practice had a lift to improve access to the first floor of the surgery.
- Translation services were available.
- The practice had recently undergone some alterations to the reception and waiting area. This included an area which could be used if patients wanted a private area to talk to reception staff.
- The practice were taking part in a pilot for a local teledermatology service in conjunction with the SouthWest Lincolnshire Clinical Commissioning Group. This pilot enabled the GPs to photograph skin lesions and send the images securely to a Consultant Dermatologist to diagnose whether further treatment was necessary or not. This, in most cases, saved patients a journey to hospital.

Access to the service

Patients had telephone access to the practice from 8.00am to 6pm Monday to Friday. The practice doors open from 8.30am to 6.30pm Monday to Friday. Appointments were from 8.50am to 10.40am and 3.30pm to 5.40pm. Extended hours appointments were offered on a Tuesday evening from 6.30pm to 8.00pm and every Saturday from 8.50am to 11.30am. Telephone consultations and urgent appointments were available on the day for people that needed them. Appointments could be booked on line for GPs and could be booked up to four weeks in advance.

Results from the January 2016 national patient survey showed that patients' satisfaction with how they could access care and treatment was better than local and national averages except for the practice opening hours.

- 68% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 79% patients said they could get through easily to the surgery by phone compared to the CCG average of 75% and national average of 73%.
- 70% patients said they always or almost always see or speak to the GP they prefer compared to the CCG average of 59% and national average of 59%.

Most comments cards we reviewed told us that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- After the inspection the practice sent us their complaints policy. It was not practice specific and it did not identify who the designated responsible person was who handled the complaints.
- We saw that information was available to help patients understand the complaints system summary leaflet available in reception and information on the practice website.
- The practice had received 10 complaints since the last inspection in September 2015. We looked at three complaints in detail and found they were dealt with in a timely way with openness and transparency.
- At the inspection in September 2015 we looked at minutes of meetings but could not see where these had been discussed with staff or where lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. At

Good

Are services responsive to people's needs?

(for example, to feedback?)

this inspection we found that complaints were an item on staff meeting minutes for 20 May 2016 and 5 July 2016. On earlier meeting minutes we reviewed we did not see any evidence of complaints that had been discussed or where lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. The practice had not completed an analysis of themes and trends.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. Their mission statement was to deliver caring, safe and high quality care to all their patients without losing sight of traditional friendly primary care values.
- The practice had identified a number of challenges for the practice which included a continued increase in the number of patients registered with the practice, workload, waiting times for secondary care services, patient expectations and a change in computer system.
- The GP partners met every month. We saw meeting minutes which reflected the vision and values which had been regularly monitored since the last inspection. Since the last inspection the partners felt that there had been some positives changes. Staff felt that the leadership had improved.

Governance arrangements

At the inspection in September 2015 we found there were limited governance arrangements in place, including a poor system for significant events, safeguarding patients, assessing and monitoring risk, not having an on-going system of clinical and internal audits or the recall of long term conditions and vaccination programmes.

At this inspection the practice had a governance framework in place but it was still ineffective and the associated systems and processes did not support the delivery of their strategy. We also found a lack of accountability at the practice management level. For example, a number of issues which had been identified by us in September 2015 had not been addressed or not been addressed effectively. This was particularly concerning in respect of significant event reporting, monitoring of risk and safeguarding as there appeared to be a lack of oversight as to the purpose and importance of these processes. This has led to on-going breaches of regulation.

We found:-

- There was a more open approach to reporting significant events but improvements were still required to ensure reviews and investigations were thorough, learning disseminated and identified actions implemented in order to improve safety.
- There had been improvement in systems and processes for safeguarding. However it was still did not protect patients from abuse and improper treatment. For example in respect of dealing with safeguarding referrals from external agencies such as East Midlands Ambulance Service. We found that a referral that had been made in February 2016 and had still not been actioned.
- The practice still had not done all that was reasonably practical to identify, record and manage risks or implement mitigating actions to protect the health, safety and welfare of people who used the service..
- The practice had undertaken four clinical audits since the last inspection. We did not see any evidence that they had been discussed in meeting minutes we looked at. Some actions were identified but no action plan had been put in place to ensure these were completed.
- We looked at meeting minutes and saw that significant events, safeguarding, complaints, palliative care, admission avoidance, NICE guidance, QOF, CQC revisit had been discussed. However some minutes lacked detail and it was therefore difficult to identify a time frame and who was responsible for the identified actions and what learning had been shared with staff.
- At the inspection in September 2015 we found the practice did not have an effective system in place for the summarising of paper records for new patients who had registered with the practice. At this inspection we found that the practice had employed an external company to summarise paper records. They had sent a large number of records to this company and had a further 35 which still required summarising. We asked what the trigger point in terms of records waiting for summarisation was but the management team had not formalised the process. They told us they would review this after the inspection.
- We found that the staffing structure was not clear as there was no clarity in the practice management roles. The practice had taken on an acting practice manager to support them whilst in special measures. On the day

Are services well-led?

Inadequate

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

of the inspection the registered manager informed us that the practice manager was on pre-booked annual leave and the deputy practice manager was not available as they had recently returned to work following compassionate leave.

- The practice had a number of clinical policies in place to govern activity and these were available to staff within the practice. Some lacked detail or contained out of date information.
- We looked at the nurse protocols and found that a number were overdue for a review. For example, asthma, atrial fibrillation and alcohol.

Leadership and culture

Although the partners were positive about future plans we found that the practice was unable to demonstrate strong leadership in respect of safety.

Since the last inspection the practice had undergone further changes and had appointed two further GP partners and two salaried GPs. Staff we spoke with told us the partners were approachable and took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. We saw meeting minutes for May 2016 where a GP partner had informed staff about significant events and the process they needed to follow.

The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- We did not see any evidence that the practice kept written records of verbal interactions as well as written correspondence.

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

The practice had taken steps to encourage feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- At the inspection in September 2015 we found that the practice had not carried out a patient survey since 2014. At this inspection we found that a patient survey was in progress. As it had not yet finished there was no analysis available. We saw that NHS choices had been responded to. The practice patient participation group had recently changed from a virtual group to a group who had face to face meetings on a regular basis.
- The practice participated in the Family and Friends testing (FFT).The reception team at the practice promote FFT in the waiting room to encourage patients to participate and give the practice feedback. We saw that the practice collated the data on a regular basis but did not see any evidence that this was discussed and an action plan put in place to address any issues raised.
- At the inspection in September 2015 we were told that the practice had gathered feedback from staff through staff meetings and appraisals but had not always acted on it. Some staff told us there were times when they did not feel supported. At this inspection we found that most staff had received an appraisal, regular meetings took place and new systems and processes had been put in place. Staff we spoke with felt there had been a lot of improvement since the last inspection.
- At the inspection in September 2015 staff told us that the practice supported them to maintain their mandatory two day training each year but did not have the time for clinical professional development through training, mentoring and to attend meetings. Two members of staff told us they did not have enough time to supervise staff as they were always part of the working team. This had been raised with the management team. At this inspection we found that the current nurse lead was leaving at the end of the September and a practice nurse had been promoted. They were also the infection control lead. At the time of the inspection several meetings had taken place with the infection control nurse to establish how much time

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she would have to undertake her duties as Nurse Manager in addition to that of infection control lead. However no final decision had been made on the day of the inspection.

- The practice had gathered feedback from staff through staff meetings, appraisals and daily informal conversations. Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Most staff said they felt respected, valued and supported, particularly by the partners in the practice. Staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example,

- The management team told us they were going to install a new computer programme at the end of July 2016 which would provide them with an intranet system that has a central and accessible store for documents and information which would be accessible by all practice staff.
- The practice were taking part in a pilot for a local teledermatology service in conjunction with the SouthWest Lincolnshire Clinical Commissioning Group. This pilot enabled the GPs to photograph skin lesions and send the images securely to a Consultant Dermatologist to diagnose whether further treatment was necessary or not. This, in most cases, saves patients a journey to hospital.
- Two GPs were interested in developing the practice as a training practice.
- The GP partners had plans to recruit a permanent business manager to make improvements and further develop the practice in the future.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have in place systems and processes which were established and operated effectively to enable them to: (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); and (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. This was in breach of Regulation 17 1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014