# The University of Lincoln Health 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 | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires improvement |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as Requires Improvement overall.** (This is the first inspection).

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Not rated

People with long-term conditions – Requires improvement

Families, children and young people – Requires improvement

Working age people (including those recently retired and students – Requires improvement

People whose circumstances may make them vulnerable – Not rated

People experiencing poor mental health (including people with dementia) – Requires improvement

We carried out an announced comprehensive inspection at The University of Lincoln Health Centre on 14 February 2018. This inspection was carried out as part of our inspection programme.

At this inspection we found:

- Clinical leadership and governance systems needed to be strengthened. Some staff did not feel able to raise concerns and there was a disconnect between the leadership team and staff.
- There was a system for recording and acting on significant events and incidents but this needed to be reviewed. Some significant events were not discussed at meetings and the process for reporting, discussing, recording and learning from significant events, including reviewing themes and trends was not always effective.
- The practice did not have an effective system in place to gain the assurances required that nurse-led services were of sufficient quality.
- Patients said they were treated with dignity, respect and compassion and they were involved in their care and decisions about their treatment.
- We saw evidence pathology results were not reviewed and actioned every day.
- Information about how to complain was not clearly displayed in the reception area or available on the

# Summary of findings

practice website. Patients told us they did not know how to complain. On the day of the inspection, the practice amended the leaflet title to include the wording 'How to Complain'. Complaints were not discussed at practice meetings in sufficient detail to learn from them or to consider trend analysis.

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- We saw evidence the practice actively sought patient feedback and the practice had made improvements to patient access.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

More detail can be found in the Requirement Notices section at the end of this report.

The areas where the provider **should** make improvements are:

- Review the newly implemented system for monitoring prescriptions through the practice to ensure it is embedded.
- Review the emergency drugs ordering system so the practice has sufficient stock of emergency drugs.
- Review risk assessments to ensure the practice retains oversight and that all risk assessments are up to date.
- Review the training system so practice staff are up to date with mandatory training.

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector 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**
We rated the practice as Not rated for Older people

**People with long term conditions**
We rated the practice as Requires improvement for People with long term conditions

Requires improvement 

**Families, children and young people**
We rated the practice as Requires improvement for Families, children and young people

Requires improvement 

**Working age people (including those recently retired and students)**
We rated the practice as Requires improvement for Working age people (including those recently retired and students)

Requires improvement 

**People whose circumstances may make them vulnerable**
We rated the practice as Not rated for People whose circumstances my make them vulnerable

**People experiencing poor mental health (including people with dementia)**
We rated the practice as Requires improvement for People experiencing poor mental health (including people with dementia)

Requires improvement 

# The University of Lincoln Health 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 adviser, a CQC inspection manager and a CQC inspector.

## Background to The University of Lincoln Health Centre

The University of Lincoln Health Centre provides services to approximately 9,500 registered patients in Lincoln, Lincolnshire, the significant majority of which are students aged between 17 and 26 years old. University of Lincoln students and staff plus partners and dependents of both, are eligible to register as patients. The practice list size has increased by around 3,000 patients from September 2016 to February 2018. The practice is run by two female GPs who are supported by a lead nurse practitioner, three nurse practitioners, two practice nurses and a healthcare assistant. The practice employs a practice manager, trainee manager and secretarial and administration staff.

The University of Nottingham Health Service is the name of the registered provider and the practice holds an alternative provider medical services (APMS) contract with NHS England. Services are provided at The University of Lincoln Health Centre, 3 Campus Way, Lincoln Lincolnshire LN6 7GA and this location was inspected.

The practice is open from 7:30am – 6:30pm on Monday, Tuesday, Wednesday and Friday. On Thursday the practice opens from 7:30am – 7:45pm. The phone lines operate between 8am and 6:30pm Monday to Friday. When the practice is closed patients are automatically directed to the GP out of hours service. Patients can also access advice via the NHS 111 service.

NHS Lincolnshire West Clinical Commissioning Group (LWCCG) is responsible for improving the health of and the commissioning of health services for patients living in Lincoln, Gainsborough and the surrounding villages. There are significant health inequalities in Lincolnshire West, linked to a mix of deprivation, access, mix of lifestyle factors and use of healthcare.

We reviewed the most recent data available to us from Public Health England which showed the practice has 98% of patients in paid work or full-time education compared to the CCG average (60%) and the national average (62%). Patient numbers aged 65 or higher are minimal as are those aged 14 years or younger. The practice deprivation score is 27% which sits within the fourth most deprived decile. This compares to the CCG deprivation score of 20% and the national deprivation score of 23%.

Requires improvement

# Are services safe?

## Our findings

**We rated the practice as requires improvement for providing safe services.**

**We rated the practice as requires improvement for providing safe services.**

**Safety systems and processes**

We found some of the systems, processes and practices in place to keep people safe and safeguarded from abuse were not effective.

- The practice held staff files on site which did not contain evidence of all staff checks of professional registration and recruitment. We looked at five staff files and all contained some missing information such as proof of identity, full employment history, references and 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). Staff told us some documentation was difficult to obtain as several staff had transferred from the previous provider and further documents were stored at the sister site at the University of Nottingham Health Service. The provider had risk assessed that no further checks for staff employed prior to them taking on the practice were required. The provider told us all staff had a DBS check but we were unable to see evidence of this.
- The provider told us that all staff had received up-to-date safeguarding and safety training appropriate to their role. However the training log showed some staff had not received training in line with the practice policy. For example, some mandatory training had not been recorded as completed, this included safeguarding children and young adults, safeguarding adults, information governance and fire safety training. The practice had systems to safeguard children and vulnerable adults from abuse. Staff we spoke with knew how to identify and report safeguarding concerns and who to go to for further advice. We saw safeguarding pathway information which staff used to show them who to report their concerns to and how to escalate should that staff member be unavailable. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice conducted some safety risk assessments. For example, safe sharps policy, isolation policy and guidance and hand hygiene policy. Some policies were due for review such as the waste management policy. the COSSH assessments for products stored in the cleaners cupboard were dated 2015. Staff received safety information for the practice as part of their induction and refresher training. Most policies were regularly reviewed and were accessible to all staff.
- There was a system to manage infection prevention and control and regular infection control audits.
- The practice ensured that the facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We saw evidence of a recent fire drill with actions and findings. The domestic water system hygiene survey (Legionnaires Disease risk assessment) was last carried out in 2015. On the day of the inspection, the practice contacted the premises manager and asked for the next review to be booked and this has now been carried out.

**Risks to patients**

There were some systems to assess, monitor and manage risks to patient safety.

- Some staff told us administration staffing levels had not been sufficient for the workload. Evidence showed us some administration tasks had fallen behind which could have impacted on patient safety, for example, managing daily correspondence. Since the inspection, the practice have increased the size of the administration team to reflect an increased list size.
- We saw pathology results were generally reviewed and actioned quickly. However, on the day of the inspection we found the pathology in-box had not been checked, reviewed and actioned every day. Two pathology results from 24 January and 1 February had been reviewed but not actioned. The provider told us that after review the actions would be paused until the patients' named GP was available, unless urgent action was required.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in

need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example sepsis. Reception staff did know how to recognise a sick patient, but did not know the signs and symptoms of sepsis. Since the inspection they have provided sepsis awareness training to all frontline staff.

**Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- On the day of the inspection, we saw referral letters included all of the necessary information.

**Safe and appropriate use of medicines**

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had started to log prescriptions to improve security but improvements needed to be made so that prescriptions could be tracked through the practice. Before the inspection the practice had identified they did not have all emergency drugs required and had ordered them. Vaccines were kept and stored safely with practice staff logging temperature checks in line with current guidance.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. There was evidence of actions taken to support good antimicrobial stewardship.

**Track record on safety**

The practice had not undertaken all risk assessments in relation to safety issues.

- We saw evidence to show external contractors had carried out regular cleaning and contamination schedules. There were risk assessments in relation to safety issues such as samples handling policy, cleaning clinical equipment and decontamination.
- The practice monitored and reviewed some activity which helped it to understand risks.

**Lessons learned and improvements made**

The practice did not always learn and make improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. However, this was not always effective and the practice policy was not always followed. One incident recorded as having taken place on 24 January 2018, had been placed in the significant event folder but had not yet been reported as such. It had not yet been investigated or added to the significant event log. The policy states that the significant event reporting form should be completed as soon as possible after the incident, but no longer than 2 weeks after. Staff told us this significant event did not exist in that form at the time of the inspection and therefore would not have formed part of the log or any team discussions. It has subsequently been written up as a significant event. Staff did not fully understand their duty to raise concerns and report incidents and near misses.
- Some significant events were not discussed at practice meetings and meeting minutes showed significant events were recorded as a routine agenda item. This meant they were not flagged as a significant event. There was evidence to show discussions had taken place for some significant events but the detail was not documented every time. Some learning had taken place and action had been taken to improve safety in specific areas. However, the practice did not identify themes to reduce the likelihood of future significant events taking place.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as requires improvement for providing effective services overall.**

**Effective needs assessment, care and treatment**

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group was 0.24 compared to a CCG average of 1.29 and national average of 0.9.
- The average number of antibacterial prescription items prescribed per Specific Therapeutic group was 0.35 compared to a CCG average of 1.07 and national average of 0.98.
- The percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones was 4% compared to a CCG average of 11% and national average of 9%.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older people formed 0.01% of the practice patients.
- There were no patients with osteoporosis or rheumatoid arthritis.

People with long-term conditions:

- The practice had relatively small numbers of patients with long-term conditions. For example 0% with chronic obstructive pulmonary disease, CCG and national average 2%; 0.04% with atrial fibrillation, CCG and national average 2%; 0.1% with hypertension, CCG - 2% and national average 3%; 0.7% with diabetes, CCG and national average - 7%. Asthma levels at 5% were more in line with CCG and national averages of 6%.
- Patients' health with long term conditions was not always monitored in a timely manner to ensure medicines were used safely and followed up appropriately.
- 26% of patients with diabetes had received a review where the last IFCC-HbA1c was 64 mmol/mol or less in the preceding 12 months. This compared to the CCG average of 81% and the national average of 80%.
- 63% of patients with asthma had received a review in the last 12 months compared to the CCG and national average of 76%.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.

Families, children and young people:

- The practice list contained low numbers of patients below 16 years of age and these formed approximately 0.1% of the patient list. Childhood immunisations were carried out in line with the national childhood vaccination programme.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- Although the practice population contained fewer patients eligible for cervical screening, the practice's uptake was only 31%. This was not in line with the 80% coverage target for the national screening programme. (The CCG average was 77% and the national average was 72%). It was unclear what action the practice were taking to improve this.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. These patients formed 0.05% of the practice list compared to the CCG (0.58%) and national average (0.47%).

People experiencing poor mental health (including people with dementia):

- 0% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a

Requires improvement

# Are services effective?

## (for example, treatment is effective)

comprehensive, agreed care plan documented in the previous 12 months. This is worse than the CCG average of 83% and the national average of 90%. The practice had patient numbers below ten with this diagnosis.

- The practice did not always consider the physical health needs of patients with poor mental health. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 38%; CCG 85%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 81%; CCG 95%; national 95%).
- There was a lower number of patients with a mental health condition (practice 0.15%; CCG 0.78%; national 0.77%).
- 37% of patients aged 18 or over with a new diagnosis of depression had their care reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis. This compared to the CCG average of 73% and the national average of 84%.
- 6% of the practice population had been diagnosed with depression compared with the CCG average of 11% and the national average of 9%.
- The practice had no patients diagnosed with dementia.

**Monitoring care and treatment**

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. Audits were carried out to ensure vaccine storage was safe, ADHD patients were supported appropriately and documentation was correct.

The most recent published Quality Outcome Framework (QOF) results were 47% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 97%. The overall exception reporting rate was 13% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

As students aged between 17 and 26 primarily form the University of Lincoln Health Service patient list, many of the QOF indicators reflected results of 0%. These included chronic kidney disease, COPD, dementia, heart failure, osteoporosis, peripheral arterial disease and rheumatoid arthritis. Patients aged 47 or above made up 0.25% of the patient list, with one patient 67 or older.

- The practice was involved in quality improvement activity and carried out audits. For example, on high risk medication, that antipsychotic prescribing was in line with current guidelines.

**Effective staffing**

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop and achieve additional qualifications in areas such as travel medicine, asthma, sexual health, diabetes and occupational health.
- The practice provided some staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

**Coordinating care and treatment**

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- Staff told us the practice had no palliative care patients.

**Helping patients to live healthier lives**

Requires improvement

# Are services effective?

## (for example, treatment is effective)

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients with mental health issues, those at risk of leaving their studies due to ill health and patients who had experienced sexual assault.
- The practice had very low numbers of new cancer cases (Only 1). 0% were referred using the urgent two week wait referral pathway compared to the CCG average of 51% or national average of 52%.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity, improving sexual health and mental health.

**Consent to care and treatment**

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

# Are services caring?

## Our findings

**We rated the practice as good for caring.**

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. However, on the day of the inspection, a conversation could be heard between a patient and a clinician from the corridor outside of the consultation rooms.
- Clinicians collected patients from the reception area when they were ready to be seen.
- All of the seven patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 383 surveys were sent out and 34 were returned. This represented about a 9% response rate; the average national response rate was 39%. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 83% of patients who responded said the GP gave them enough time; CCG – 83%; national average – 86%.
- 96% of patients who responded said they had confidence and trust in the last GP they saw; CCG – 96%; national average – 96%.
- 90% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 87%; national average – 86%.
- 87% of patients who responded said the nurse was good at listening to them; CCG – 94%; national average – 91%.
- 90% of patients who responded said the nurse gave them enough time; CCG – 90%; national average – 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG – 96%; national average – 97%.
- 88% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG – 94%; national average – 91%.
- 91% of patients who responded said they found the receptionists at the practice helpful; CCG – 91%; national average – 87%.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Staff told us interpretation services were available for patients who did not have English as a first language. We were unable to see notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand. Posters in the reception area displayed information about the Accessible Information Standard.
- Staff helped patients find further information and access community and advocacy services should these be required. They helped them ask questions about their care and treatment. Patients told us they felt involved in decisions about their care and treatment.

The practice proactively identified patients who were carers through the new patient registration process. The practice's computer system alerted GPs if a patient was also a carer although there were currently no patients identified as such. Staff told us students often did not self-identify as carers even though they may have had caring responsibilities at weekends and outside of term time.

Good

# Are services caring?

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 were in line with local and national averages:

- 83% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 80% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG – 83%; national average – 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG – 93%; national average – 90%.
- 91% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG – 90%; national average – 85%.

**Privacy and dignity**

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice as good for providing responsive services.**

**Responding to and meeting people's needs**

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. The practice was open from 7:30am to 6:30pm on Monday, Tuesday, Wednesday, Thursday and Friday with extended opening hours on Thursday between 6:30pm and 7:45pm. This day had been chosen due to student timetabled activity taking place which the practice told us would result in more students being on campus. Online services were offered such as repeat prescription requests, advanced booking of appointments and advice services for common ailments. Patients received a text message confirmation of their appointment time and date which also allowed them to respond and cancel. Nurse practitioners offered Skype consultations to patients for mental health reviews. Patients were able to register for the practice by completing a form online or filling out a paper form in reception.
- The practice ran regular health promotion events and targeted the freshers and refreshers fayres. Staff used social media to publicise events to try and maximise attendance. The reception area incorporated health promotion displays including chlamydia screening on Valentine's day, sexual and mental health support. The practice operated as a C-Card registration and distribution centre offering free condoms to patients under 25 who registered with the service. Patients were able to access emergency contraception, contraception repeat clinics and a coil and implant service was available.
- The practice improved services where possible in response to unmet needs. Following patient feedback the practice had updated the telephone system which allowed the practice to better monitor demand and improve access.
- The facilities and premises were appropriate for the services delivered and were situated on the ground floor. Staff told us plans had been submitted to add three additional consulting rooms and to revamp the waiting area.
- Some practice staff were able to work flexibly in line with the university term dates allowing the practice to provide more staff hours when they were needed.
- The practice made reasonable adjustments when patients found it hard to access services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- Home visits and urgent appointments were offered to those with enhanced needs and those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition did not always receive an annual review to check their health and medicines needs were being appropriately met. Consultation times were flexible to meet each patient's specific needs.

Families, children and young people:

- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours were available to patients on a Thursday. This supported patients who were unable to attend the practice during normal working hours.
- Longer appointments were available for patients who may need more time such as international students.

People whose circumstances make them vulnerable:

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

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs.
- The nurse practitioner offered web consultations for mental health reviews.
- The practice offered a welcome day for new students with mental health issues prior to the start of term.
- Extended appointments were available for patients with mental health support needs.

**Timely access to the service**

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients with the most urgent needs had their care and treatment prioritised.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients who requested a same day or emergency appointment were assessed by a clinician on the same day.
- Patients told us the appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 383 surveys were sent out and 34 were returned. This represented 0.004% of the practice population.

- 85% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 84% and the national average of 80%.
- 82% of patients who responded said they could get through easily to the practice by phone; CCG – 72%; national average – 71%.
- 81% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG – 75%; national average – 76%.
- 80% of patients who responded said their last appointment was convenient; CCG – 80%; national average – 81%.
- 66% of patients who responded described their experience of making an appointment as good; CCG – 73%; national average – 73%.
- 87% of patients who responded said they don't normally have to wait too long to be seen; CCG – 87%; national average – 64%.

**Listening and learning from concerns and complaints**

Although the practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care, the system for dealing with complaints needed strengthening.

- The practice told us they welcomed complaints and patient feedback. However, information about how to make a complaint or raise concerns was not clearly displayed in reception or on the practice website. Instead there was a leaflet called 'Patient Feedback' which contained information inside about how to complain. This included information about support available to complain and what to do if the practice did not resolve the complaint. Patients we spoke with told us they did not know how to complain. On the day of the inspection the practice amended the leaflet 'How to complain / give patient feedback'. Patients were able to give feedback using the 'Tell Dan' patient feedback box, the Friends and Family Test and practice questionnaires.
- The complaint policy and procedures were in line with recognised guidance. Five complaints were received in the last year. We reviewed all five and found they were satisfactorily handled in a timely way. However, the complaint log showed one complaint was still being investigated while the complaint form stated the complaint was closed. Another complaint log item indicated a discussion at a clinical meeting but meeting minutes did not reflect this. Staff treated patients who made complaints compassionately.
- Staff told us complaints were a standing agenda item at practice meetings but meeting minutes we looked at did not show this. Meeting minutes showed the practice team had discussed the complaints log and all complaints received in the last year at one recent meeting. However, the detail of the discussions was not recorded and there was no analysis of trends. Any learning or resulting improvements in the quality of care was difficult to establish.

# Are services well-led?

Requires improvement

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

## Our findings

**We rated the practice as requires improvement for providing a well-led service.**

### Leadership capacity and capability

Leaders did not always demonstrate they had a clear understanding of some of the systems and processes in place at the practice.

- Staff told us the practice had previously been run down and since the new provider had taken over, significant progress had been made. Although the partners and practice management team were experienced in the delivery of care, there was a lack of co-ordinated strategy and approach in place to ensure effective clinical governance. For example, leadership and clinical governance needed to be strengthened to ensure the leadership team were assured about patient safety, nurse-led services, significant events, complaints and infection control.
- The practice had employed a GP starting in April 2018 who will act as the clinical lead.
- The practice had considered plans to develop leadership capacity and skills, including planning for the future leadership of the practice. A trainee manager worked part time in the practice and other staff were encouraged to undertake leadership development.

### Vision and strategy

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

- We saw the partners were positive about future business plans. Staff showed us plans to develop the building to increase the number of consulting rooms and to improve the patient waiting area.
- Staff were aware of and understood the vision, values and strategy but there was a discrepancy between this and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. We saw evidence the practice had monitored patient use of the Lincoln walk in centre from October 2016 to January 2018. Although the patient list size had increased from almost 6,800 to 9,350 during this period, walk in centre attendance levels had remained consistent in number so falling as a percentage.

### Culture

The practice did not always demonstrate it had a culture of high-quality sustainable care.

- Some staff stated they did not always feel respected, supported and valued. Some staff we spoke with told us they were not always able to raise concerns and when they were raised, they did not feel listened to.
- The practice focused on the needs of patients. Staff told us they were proud of the work they had carried out within the practice.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- Staff told us they spent regular social time together away from the practice and this was valued by the practice team. There were positive relationships between staff and teams.
- The practice actively promoted equality and diversity and staff had received equality and diversity training. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.

### Governance arrangements

There were clear responsibilities, roles and systems of accountability to support a governance framework but not all the systems in place operated effectively.

- Practice leaders had established policies, procedures and activities to ensure safety but these needed to be

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Requires improvement

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

reviewed to provide the necessary assurance they were operating as intended. For example, some clinical staff were unaware that any significant events had taken place.

- The practice was unable to demonstrate strong leadership in some areas such as oversight of the following: training sufficient staff levels to cover administrative duties.
- Although practice leaders were experienced, the practice had not sought the assurance required that nurses were working within scope and competency. Although there was evidence of some clinical decision making audits including non-medical prescribing, the practice need to strengthen its assurance processes. From April the practice told us the work of the new clinical lead will include oversight of nursing clinical practice.
- Patients health was not always monitored in a timely way to ensure medicines were used safely and followed up on appropriately. For example patients with diabetes had not had their HbA1c levels checked regularly and patients experiencing poor mental health had not had a care plan agreed or had alcohol consumption checked.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

**Managing risks, issues and performance**

There were clear processes for managing risks, issues and performance, however these weren't always followed.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the mechanism in place to allocate pathology results should the named GP be absent from the practice was not clear on the day of the inspection, the provider later clarified the system.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts but incidents and complaints processes needed strengthening.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of action to change practice to improve quality. The practice held an audit summary which identified audits carried out, dates and actions and outcomes. However, there was no current infection control audit.
- The practice had continuity and recovery plans in place but these had not been updated following a relevant significant event.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

**Appropriate and accurate information**

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. For example patient feedback had led to improved accessibility.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information to inform reporting and monitoring.
- The practice used information technology systems to monitor and improve the quality of care. Identifiers were used to highlight patient needs on the electronic record.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

The practice involved patients, the public, staff and external partners to support quality sustainable services.

- Patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The practice encouraged patient feedback through the practice patient survey and Tell Dan scheme. Practice staff surveyed 118 patients in January 2018 during the refreshers fayre for the practice patient survey and 109 patients said they were likely or very likely to recommend the practice to a friend or family member. We saw a Patient Feedback Report 2017-18

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which highlighted some of the positive and negative responses received but did not provide enough detail or analysis to gain a thorough understanding of patient views. The Tell Dan scheme enabled patients in reception to comment on the practice services and patient experience. Since September 2017, the practice have used the Friends and Family Test to text patients after their appointments and ask if they would recommend the practice. Two per cent of patient responses were received with 76% of patients willing to recommend the practice. We saw Friends and Family Test forms displayed in the reception area. There was also a patient feedback form but this contained information about how to complain.

- The practice had engaged with the Students Union as staff told us recruiting student patients to join the PPG had been problematic. Representatives from the Students Union had spoken to patients, been involved in asking for feedback about the practice and were in the process of creating an action plan for future initiatives.
- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

There were limited systems and processes for learning, continuous improvement and innovation.

- The practice did not make effective use of internal and external reviews of incidents and complaints. For example, a significant event record action plan stated the business continuity plan should be reviewed to include learning from the significant event. The most recent business continuity policy we looked at did not refer to this and the significant event learning had not been applied to the policy so it could be updated.
- There was a focus on continuous learning and improvement at some levels within the practice. The practice was research–accredited and had five clinical trials running at the time of the inspection.
- Staff knew about improvement methods and had the skills to use them.
- Evidence we saw showed leaders and managers encouraged staff to review individual and team objectives, processes and performance.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br><br>How the regulation was not being met.<br>The registered person had systems or processes in place that were not operating effectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:<br>• An effective system or process for ensuring sufficient leadership capacity and clinical oversight of nurse practice so leaders were assured of effective governance, was not in place.<br>• An effective system or process for reporting, discussing, recording and learning from significant events, including reviewing themes and trends was not in place.<br><br>The registered person had systems or processes in place that were not operating effectively in that they failed to enable the registered person to seek and act on |

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# Requirement notices

feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular:

- An effective system or process to ensure the practice shared learning from patient complaints was not in place.

Regulation 17(1)