Suttons Medical Group

Quality Report

Long Sutton Medical Centre
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Date of inspection visit: 1 December 2014
Date of publication: 10/04/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Long Sutton Medical Centre on 01 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that 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.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

In addition the provider should:

Summary of findings

- Improve the arrangements for dispensing medicines. This includes reviewing the Standard Operating Procedures (SOPs) for medicines management and update these annually. Dispensing staff should also follow the clinical audit and incident reporting procedures; and make arrangements for dispensing assistants to receive regular knowledge and competency checks.
- Make arrangements for nurses to continue to access clinical supervision as already established by the practice.
- Arrange for policies and procedures to be regularly reviewed and updated including the whistleblowing policy, and child protection 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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Systems were in place to ensure the environment and equipment were clean and staff followed hygienic procedures to minimise the risk of infection. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. The arrangements for dispensary services were not well organised and needed review around Standard Operating Procedures (SOPs) audits, incident reporting, and staff knowledge and competence. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) guidelines and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice as good. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Patients concerns and complaints were listened and responded to and used to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures however we found a number were out of date. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was due to reform in early 2015. The PPG includes representatives from various population groups, who work with staff to improve the service and the quality of care and services. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All patients 75 years and over were allocated a named GP to offer continuity of care to ensure that their needs were being met. Care plans were provided for patients over 75 years, to help avoid unplanned admissions to hospital. Carers were identified and supported to care for older people. Home visits were carried out for older patients who were housebound and those requiring end of life care. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. All patients were offered an annual review including a review of their medication, to check that their health needs were being met. When needed, longer appointments and home visits were available. Where possible, clinicians reviewed patients with long term conditions and any other needs at a single appointment, to prevent them from attending various reviews. Emergency processes were in place and referrals were made for patients who had a sudden deterioration in their health. For those patients with the most complex needs, a named GP worked with relevant health and care professionals to deliver multi-disciplinary support and care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. The practice worked in partnership with midwives and health visitors. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours to enable children to attend. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice provided extended opening hours to enable patients to attend in an evening or early morning. Patients were also offered telephone consultations and were able to book non-urgent appointments around their working day by telephone, on line. The practice offered a choose and book service for patients referred to secondary services. This enabled patient's greater flexibility over when and where their tests took place, and first outpatient appointments at hospital. NHS health checks were offered to patients over 40 years. The practice was proactive in offering health promotion and screening appropriate to the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients with a learning disability were offered an annual health review, including a review of their medication. When needed, longer appointments and home visits were available. The practice was part of a local scheme to support the most vulnerable patients with the aim of managing their needs at home and avoiding unplanned hospital admissions. The practice worked with multi-disciplinary teams in the case management of people in vulnerable circumstances and at risk of abuse.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia) The practice held a register of patients experiencing poor mental health. Patients were offered an annual health, including a review of their medicines. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health, to ensure their needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access emergency care and treatment when experiencing a mental health crisis. Psychiatry and counselling services were reduced for this patient group due to limited local resources. The GPs were planning for IAPT (Improving access to psychological therapy) services to be set up in the practice. (Currently IAPT is provided by another organisation).

Summary of findings

What people who use the service say

During our inspection we spoke with 16 patients including one member of the Patient Participation Group (PPG). The PPG includes patient representatives who work with the practice to improve the quality of care and services. The PPG group had stopped operating for a while and the group were looking to re-form. Prior to the inspection, the Care Quality Commission (CQC) received 25 comment cards from patients. We also spoke with representatives of four large care homes (for older people and younger adults) where patients were registered with the practice**.**

Patients and representatives we spoke with felt that the practice was well managed. Patients considered that the premises were clean, and that the facilities were accessible and appropriate for their needs. They also said that they felt safe and listened to, and able to raise any concerns with staff if they were unhappy with the care or the service. They knew how to make a complaint. Patients described the staff as friendly and caring, and said that they felt that they treated them with dignity and respect.

Patients told us they were involved in decisions about their care and treatment, and were satisfied with the care and service they received. They were promptly referred to other services and received test results, where appropriate. Four care homes we spoke with praised the support staff received from the practice, and the care and service patients received**.** They said that patients were promptly seen and their needs were regularly reviewed.

Representatives of the PPG told us they had set up around 2003/4 and worked in partnership with the practice, and were looking forward to re-establish the PPG.

We looked at the July 2014 national patient's survey. The findings were compared to the regional average for other practices in the local Clinical Commissioning Group (CCG) and compared above average. Patients expressed 80 % satisfaction with the practice. Areas for improvement included access to appointments, and getting through to the practice by phone.

Areas for improvement

Action the service SHOULD take to improve

Improve the arrangements for dispensing medicines. These include reviewing the Standard Operating Procedures (SOPs) for medicines management and update these annually. Dispensing staff should also follow the clinical audit and incident reporting procedures; and make arrangements for dispensing assistants to receive regular knowledge and competency checks.

Make arrangements for nurses to continue to access clinical supervision as already established by the practice.

Arrange for policies and procedures to be regularly reviewed and updated including the whistleblowing policy, and child protection procedures.

Suttons Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead Inspector. The team included a GP, an additional CQC inspector, an Advanced Nurse Practitioner and an expert by experience. An expert by experience is someone with experience of using services that helps us to make judgements.

Background to Suttons Medical Group

Long Sutton Medical Centre provides services to approximately 9,360 patients in the area of Spalding Lincolnshire. The practice is situated in a rural area with two market towns and approximately 16 small villages in the surrounding area. The area served is a largely deprived rural area with the most severely deprived area in South Holland. A dispensing service is provided for patients who live more than one mile from a chemist.

The practice has a high number of patients over 75 years. The range of services provided by the practice includes minor surgery, minor injuries, family planning, maternity care, blood testing, vaccinations, mental health, and various clinics for patients with long term conditions. Ten percent of the patient group are eastern European with Latvian, Lithuanian and Polish backgrounds.

The practice employs five full time GP Partners, a full time salaried GP, a part time salaried GP (two days per week) and a part time regular locum (two days per week). There is a practice manager, a nurse practitioner, five practice nurses, four health care support assistants, eight dispensary staff, three medical secretaries and administrative and support staff. There are 53 GP sessions per week.

This service is supported by the Lincolnshire South Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

The practice has opted out of providing out- of- hour's services to patients. This service is provided by NHS Direct 111. The practice holds the following contracts: General Medical Services (GMS) to deliver essential primary care services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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. This practice had not been inspected before under our new inspection process and that was why we included them.

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.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed information about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 1 December 2014. During our visit we checked the premises and the practice's records. We spoke with various staff including, four GPs, a nurse practitioner, practice nurses, dispensing staff, health care support assistants, reception and clerical staff, and the practice manager. We reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. We spoke with patients and representatives who used the service, including one member of the Patient Participation Group (PPG). The PPG includes representatives from various population groups, who work with staff to improve the service and the quality of care. In advance of our inspection we talked to the local Clinical Commissioning Group (CCG) and the NHS England local area team about the practice.

Good

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate that it had a good track record on safety. We saw records to show that performance had been consistent over time and where concerns had arisen they had been addressed in a timely way. The manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents. We saw that the practice kept separate records of clinical and non-clinical incidents and the manager took all incidents into account when assessing the overall safety record.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. We saw how the practice manager recorded incidents and ensured that they were investigated. The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during from December 2013 to December 2014 and we were able to review these. Overall there were no clinically significant important events. However significant events and complaints were a standing items on the practice meeting agenda. There were monthly meetings held with all the GP partners and practice manager to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. All staff were aware of any that were relevant to the practice and where they needed to take action.

Whilst at the practice we observed an incident where a patient required urgent admittance into hospital. The GP dealing with the patient requested that family members were contacted to take the patient to hospital as a wait for an ambulance could be extremely lengthy. The GP tasked administrative staff with contacting family members whilst he spoke with both the Medical Assessment Unit and Accident and Emergency at the local hospital advising them of a patient he was admitting. This showed that the staff had good local knowledge of services and people, as well as responding to the incident appropriately.

Reliable safety systems and processes including safeguarding

The practice had appointed the practice manager as the dedicated lead in safeguarding vulnerable adults and children. All GPs would follow up with any safeguarding's referrals as required. All staff had received safeguarding children and adults training to enable them to fulfil this role. All staff we spoke to were aware the practice manager was the lead, and who to speak to in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. The safeguarding children protocol was last reviewed in February 2010 and information included within this protocol has been superseded by legislation and local procedure changes. The policies made reference to this being used in conjunction with the practice's consent policy. However there was no consent policy available. We looked at training records which showed that all staff had received relevant role specific training on safeguarding children and adults. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example carers and vulnerable children.

There was a chaperone policy, which was visible on the waiting room noticeboards and in consulting rooms. All

nursing staff, including health care assistants, had been trained to be a chaperone. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A nurse practitioner was qualified as an independent prescriber and received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

GPs and practice nurses carried out patient medication reviews. However records showed us that practice nurses were carrying out medication reviews with patients. We found on the new EMIS Web system nurses had ticked the box to confirm they had completed a medication review with a patient, but had not personally completed this task. This was done by the GP. Since our visit the practice is liaising with EMIS Web to remove the tick box area on the template so this does not happen again.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The lead GP for medicines attended regular prescribing meetings to keep up to date with current practice.

We looked at the dispensary service and found they were clean and tidy and generally well organised. We observed staff worked promptly to serve patients waiting at the dispensary desk, and were polite and friendly. GPs told us they dispensed medicines for approximately 60% of their patients and provided a home delivery service. We saw standard operating procedures (SOPs) were available to staff for each function performed in the dispensary. The SOPs indicated a level of competency for each task performed by each dispensing assistant. We saw the SOPs had not been updated or reviewed annually. The standard operating procedure guidance ranged from 2006, 2009 and some for 2014.

We found staff did not know about following the clinical audit and incident reporting procedures to the accountable GP. Following on from our inspection the practice manager showed us a completed dispensing record with known errors for staff working. This had not been checked by the accountable GP and was not known to all staff. Arrangements were not in place to enable staff to raise areas of concern and learn from serious untoward incidents.

We found some dispensing assistants had not received regular knowledge and competency checks. These should be checked and signed by the practice manager and accountable GP. This would ensure staff had the right training and competency assessment to perform their role.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We found an exception to this in the minor surgery room. There was an unpleasant odour in the room, the wall mounted air conditioning appliance appeared dirty. Areas of the ceiling tiles were displaced and looked uneven, and the large built in ceiling lights were yellow stained. Following on our inspection the practice manager told us the air conditioning appliance had been checked and was clean but the cream colour had faded. The ceiling lights were clean but showed an off colour. The large ceiling tiles occasionally moved due to high winds, and the odour maybe related to the flat roof drain pipe and would be investigated further. All these aspects would be kept under review by the practice manager.

Good

Are services safe?

The practice had a lead nurse for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carried out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that an infection control audit had been carried out and that areas for improvements were identified in an action plan dated May 2014. We saw plans had been ongoing with a switch of floor coverings from carpet to vinyl in six treatment rooms, paint changed to wipeable paint, and the replacement of fabric curtains around examination couches. There were ongoing plans to remove carpets in waiting rooms and replace with vinyl flooring. Minutes of meetings showed that the findings of the infection control audits were discussed with staff.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

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

The practice had a policy for the management, testing and investigation of legionella (water borne bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice manager carried out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment were routinely tested in August 2014 and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment, for example weighing scales and the fridge thermometer.

Staffing and recruitment

We looked at three sets of staff recruitment records. Two sets of records contained evidence that appropriate recruitment checks had not been undertaken prior to employment. For example one person did not have written references, another person (a clinician) did not have checks through the Disclosure and Barring Service (DBS) check. The practice manager immediately followed up the DBS checks and written references. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Following on our inspection the recruitment policy was reviewed.

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

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. There had been little turnover of staff although the practice had advertised for a nurse to join the team and they were due to start in December 2014. One GP was due to extend their hours to three days a week.

Monitoring safety and responding to risk

The practice had systems and policies in place to identify, manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, equipment and medicines management. Action plans were put in place to reduce and manage any risks. These were discussed at GP partners' and multi-disciplinary meetings. The practice had a health and safety policy, which staff had access to.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. Emergency processes were in place for acute pregnancy complications. Staff gave examples of how they responded to patients experiencing

Good

Are services safe?

a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for people receiving medication for mental ill-health.

Arrangements to deal with emergencies and major incidents

Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

The practice had arrangements in place to deal with emergencies, although these should be reviewed and updated. We saw they had a disaster handling and business continuity plan. This plan was in place to deal with only a small range of emergencies that may impact on the daily operation of the practice and the risk assessment part of the plan should be updated with more risks. The document also contained relevant contact details for staff to refer to. For example, staff contacts details and details of a heating company to contact if the heating system failed. Parts of the business continuity plan showed they had been reviewed in July 2014.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. All the medicines we checked were in date and fit for use. One GP told us they did not carry any emergency medicines in their doctor's bag, and another GP told us they carried only basic emergency medicines. Following on our inspection the GP partners agreed that is was necessary to carry essential emergency items for example aspirin and adrenalin. GPs told us they had identified a list of emergency medicines; and a new process and system were in place to check that drugs are in date and equipment were well maintained.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

We found from our discussions with the nurses and health care support assistants that staff completed thorough assessments of patients' needs in line with National Institute for Health and Care Excellence (NICE) electronic guidelines, and these were reviewed when appropriate. Staff told us how they would discuss changes in patient's health needs and offer advice or make appropriate referrals where necessary. Staff also told us that as they had worked at the practice for a significant amount of time and they were from the area, they knew their patients very well. In some cases they could identify potential changes in the health of a patient and raise it with them, if the patient had not volunteered the information.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

The practice provided end of life care in line with the Gold Standard Framework (GSF). Frontline staff provided a gold standard of care for people nearing the end of life. There were quarterly meetings to discuss end of life care with Marie Curie nurses leading terminal care. The practice had established joint working arrangements with, heart failure nurses, district nurses, and Macmillan nurses. The practice had links with and access to beds at Holbeach Community Hospital for requiring end of life care.

Patients over 75 years had a named GP to ensure continuity of care and oversee that their needs were being met. The GPs attended monthly meetings for Neighbourhood Teams for South Lincolnshire Clinical Commissioning Group (CCG). They told us these groups provided access and better communication with social services, psychiatric care and IAPT (Improving access to psychological therapy) services, community physiotherapy, Age UK representatives, community nurses including the Parkinson Disease Nurse; and well-being organization's to help improve care. As a direct result of these meetings clinicians were able to see these patients in surgery, assess appropriately, and provide personalized care plans. The meetings provided direct access to support and other providers. This had improved care for the elderly and vulnerable and those with long term conditions, mental health problems and dementia.

Patients with a learning disability were offered an annual health check, including a review of their medicines. At the end of the review the patient was provided with a health plan to meet their needs. Clinical staff worked closely with the local learning disability team to ensure all patients with a learning difficulty received appropriate care and treatment. The practice had produced care plans for the top 2% of the most vulnerable patients. These were ongoing and regularly reviewed.

Staff also worked closely with the local mental health team to ensure that patients experiencing poor mental health or dementia were regularly reviewed, and that appropriate risk assessments and care plans were in place. GPs told us they were using a dementia pilot scheme on an iPad for assessing people with dementia and set up a memory clinic. This was to become a permanent part on the EMIS Web System soon. Memory clinics were run by the health care assistants and referrals made to the Johnson Hospital memory clinic. The lead GP had plans for IAPT (Improving access to psychological therapy) services to be set up at the practice.

The practice's performance for cervical smear uptake was lower than the Clinical Commissioning Group (CCG) average and the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually.

The practice offered a range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Management, monitoring and improving outcomes for people

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

The practice showed us eight clinical audits that had been undertaken in the last year. An example of one was reviewing emergency admissions and types of referrals. The GP identified the possibility of reducing patients being admitted to hospital for a surgical admission with

Good

Are services effective?

(for example, treatment is effective)

abdominal pain. A repeat audit was carried out over a similar period of 17 weeks. The GP changed the way they dealt with abdominal pain, and this reduced the emergency admissions for patient referrals.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. GPs maintained records showing how they had evaluated the service and documented the success of any changes. The results were shared at team meetings.

Annual appraisal documents showed all clinical staff were engaged in the audit process, and we saw team meeting minutes including clinical audit results. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit per year.

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

Effective staffing

The practice had an appropriate number of key staff including medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory training required by the provider such as annual basic life support.

A good skill mix was noted amongst the GPs. Some GPs had special interests, for example one GP had a special interest in travel medicine and another interest in elderly and dementia care. GPs were up to date with their continuing professional development and all either had been revalidated or had a date for revalidation.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training. We saw evidence of the training undertaken that was comprehensive and appropriate to individual staff member's needs. For example the practice had provided wide ranging training for three healthcare support assistants. They had been trained in NHS health checks, smoking cessation, and phlebotomy (to collect blood from patients for examination in laboratories, the results of which provided valuable information to diagnosing illness).

Through the appraisal system there was a robust way of identifying poor performance and this was addressed by agreement with the practice manager / lead GP. Nurses and health care assistants told us the nurse team meetings had stopped recently due to staff leaving. The nurses hoped these meetings would re-commence with new staff in post. The nurses did not receive formal clinical supervision but supported each other informally.

Working with colleagues and other services

We found that the practice worked effectively with other service providers to meet people's needs and support patients with complex needs. Blood results, x ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and action any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice used several electronic systems to improve its communication with other providers. For example, there was a shared system with the local out-of-hour's provider to enable patient data to be shared in a secure and timely manner. For example end of life care plans were shared with out-of- hours, end of life care nurses and St Barnabas hospice team.

The GPs attended monthly meetings for Neighbourhood Teams for South Lincolnshire Clinical Commissioning Group (CCG). The practice had joint working arrangements with partner organisation's to identify patients that would

benefit from accessing the neighborhood team. The meetings provided clinicians with access to health and social care providers and other support agencies, and the information sharing and decision making had improved patients care.

Multi-disciplinary team meetings were held monthly to discuss patients with complex needs for example those with end of life care needs. The meetings were attended by GPs, practice manager, Macmillan nurses, district nurses, hospice staff and decisions about care planning were documented. Discussions also took place about patients that had died. GPs felt this system worked well and was a means of sharing important information. These meetings continued on to discuss quality and outcomes framework (QOF). QOF is a national performance measurement tool.

Information sharing

The practice had systems in place to provide staff with the information needed to offer effective care. An electronic patient record, EMIS Web, was used by all staff to coordinate, document and manage patients' care. Staff told us EMIS Web had been installed a few weeks ago and they had experienced difficulty using the new systems.

Consent to care and treatment

We found that clinical staff we spoke with were aware of the Mental Capacity Act 2005 and understood the key parts of the legislation. The training records showed that most clinical staff had received this training in 2014 and training was ongoing.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. Staff gave examples of how patient's best interests were taken into account if a patient did not have capacity. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes.

It was clear from discussions with clinical staff that arrangements were in place for patients receiving end of life care. All patients who were part of the admission avoidance had a care plan to ensure that their wishes were respected, including decisions about resuscitation and where they wished to die. This information was available to ambulance staff and local hospitals.

Health promotion and prevention

We saw that a wide range of health promotion information was available to patients and carers

On the practice's website, and the noticeboards in the surgery at both sites. New patients completed a form, which provided some information about their lifestyle and health and an initial health check. This ensured that staff had access to essential information about people's health needs, and that any tests or reviews they needed were up-to-date.

The practice nurse undertook health promotion with patients and discussed smoking cessation, weight loss and disease management issues. Specialist nurses provided a diabetes clinic including insulin initiation, a hypertension, chronic obstructive pulmonary disease (COPD) clinic, a warfarin clinic, and a weekly audiology clinic at the practice. A minor injury clinic was available on a Monday.

Infant welfare clinics were held at each surgery. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance, and there was a system in place for following up patients who did not attend.

The practice offered NHS Health checks to all patients aged 40 to 74 years. The practice also had systems in place to identify patients who needed additional support, and were pro-active in offering help. All patients with a learning disability, experiencing poor mental health, over 65 years, with long standing conditions or aged 75 years and over, were offered an annual health check, including a review of their medication.

Depression prevalence was high due to financial and rural deprivation. A mental health professional provided clinics at the practice, and a Parkinson disease nurse provided a clinic. We found the practice had joint working arrangements with a local mental health service Improving Access to Physiological Therapies (IAPT) and through the joint work with Neighbourhood Teams for South Lincolnshire.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients had completed the Care Quality Commission (CQC) comment cards to provide us with feedback on the practice. We received 25 completed cards and all were positive about the service experienced. Patients told us the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that patient records were stored securely on site. The practice had two separate rooms, which were locked, that they used to store records. These rooms were in an area not accessible by patients.

We saw that in the reception area confidentiality was maintained and people were treated in a respectful manner. Telephone calls to the practice were answered by staff in the back office, rather than the staff member on the reception desk, allowing them to deal with patients directly. The practice had a privacy line for patients to remain behind when someone was at the reception desk, maintaining confidentiality. We saw next to the dispensary window a notice asked patients to "Keep your distance." This was a reminder to patients about maintaining privacy and confidentiality.

Clinical staff we spoke with said that patients were able to request being seen by a male or female member of staff and this would always be accommodated when possible.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national patient survey 2014 information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. We found 80% of respondents to the GP patient survey described the overall experience of their GP surgery as good.

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

Patient/carer support to cope emotionally with care and treatment

Patients and their primary carers (carers being either relatives or others) were involved in their care. Carers were identified through patient's initial registration, through ongoing medical care and also through posters in both surgeries. Once identified consent forms were completed to enable carers to be fully involved in patient's care (when the patient themselves have consented) and they were also referred to social services so that appropriate support can be provided. Patients were encouraged to involve their carers in their care and treatment plans if they wished to do so.

The practice was involved in the Palliative Care Gold Standards Framework. The Gold Standards Framework (GSF) is a way of working that involves GPs working with other professionals in hospitals, hospices and specialist teams to help to provide the highest standard of care possible for patients and their families at the end of their lives. Staff told us how the practice tried to record details of patients' next of kin and power of attorney details where appropriate.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations such as: voluntary care

Good

Are services caring?

transport scheme, carer's helpline, and bereavement support. St Barnabas operated a bereavement service from their hospice in Spalding. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The lead GP attended CCG meetings and the Neighbourhood Teams for South Lincolnshire CCG. They found the relationships with these groups benefited the practice, and met the needs of different patient groups, in particular vulnerable patients. Healthwatch meetings were attended by the practice manager to aid service planning and to meet the needs of the different patient groups.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available, although these notices were in English. We did see that behind the reception desks at the practices, there was a laminated booklet in different languages that staff could use if there was any communication difficulty. This would then allow the staff to select the correct language when contacting language line.

The practice was looking to re-establish the patient participation group (PPG) and had sought advice from local managers from other GP practices on how to support and develop the PPG. The practice was liaising with local volunteers about the setting up of a support group for the carers of dementia patients.

Tackling inequity and promoting equality

The practice recognised the needs of different groups in the planning of its services. There was rural deprivation, with a large elderly population, and a migrant population. Transport links were poor; some villages had no scheduled bus services, others only once a week. The nearest walk in centre was in Peterborough 30 miles away. The local out-of-hours services were 20 miles away in Boston. The practice aimed to provide care locally as much as possible. There was a commitment from the practice to nurse practitioner and practice nurses training to ensure they were able to offer a wide range of services.

All clinical and patient areas were located on the ground floor of the buildings. We noted the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A hearing loop was fitted to the reception areas.

Access to the service

Appointments were available from 8.30 am to 6.00 pm on weekdays across both sites. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to pre-book appointments online. Some patients told us they had difficulty booking on line. The practice reported booking on line facilities and people would either telephone or drop in to book appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by the out-of- hour's service provided by Lincolnshire Community Health Services NHS Trust. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of- hour's service was provided to patients.

The practice offered a 'choose and book' service for patients referred to secondary services, which enabled them greater flexibility over when and where their tests took place, and first out patient appointments at hospital.

The practice had identified the following areas of the service which could be improved from the national patient's survey 2014: 28% of respondents found it easy to get through to the surgery by phone, compared to the Clinical Commissioning Group (CCG) data the regional average was 73%. The practice switched to a new telephone message and employed an extra member of reception staff for the busiest times. There had been an IT upgrade with EMIS Web installed a few weeks before our inspection. The patient survey showed 59% of respondents

Good

Are services responsive to people's needs?

(for example, to feedback?)

describe their experience of making an appointment as good. The CCG regional average was **77%**.The practice felt with these improvements this would hopefully enhance the patient's experience of making appointments in the future.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to four large care homes on a specific day each week, by a named GP and to those patients who needed one. The practice's extended opening hours on each week was particularly useful to patients with work commitments. This was confirmed by feedback from some patients.

Listening and learning from concerns and complaints

Suggestion boxes were in waiting rooms and the practice was planning a newsletter to better inform patients about changes in the practice. The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system. Mention was made of the complaints process within the practice leaflet. We found copies of the complaints leaflet available at the practice. The complaints leaflet had been updated recently and this was shown to us by the practice manager. However, copies of the complaints leaflet we obtained from staff were not the newer updated versions and contained information relating to the Primary Care Trust (PCT), which had been replaced by the Clinical Commissioning Group (CCG). The practice manager agreed to review this following on our inspection.

We looked at the complaints record. We found 20 complaints had been received between December 2013 and December 2014 and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the compliant. The practice reviewed complaints regularly to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Staff we spoke with felt that there was an open and transparent culture within the practice. They told us they felt able to raise concerns they had and felt listened to. There was no triage service as the lead GP felt this did not work at this practice. One clinician told us they felt the triage service should be considered again to open up more appointments for patients.

Staff we spoke with were aware of what to do if they suspected malpractice by another member of staff and how to whistleblow if need be. Staff were aware of who to speak to internally but were unsure as to where they could go to outside of the practice. We also saw that the practice did not have a whistleblowing policy in place, although there was a draft version of the policy in development.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We looked at the strategic business plan for 2014-2015. The practice provided services in-house including phlebotomy and warfarin monitoring. There were plans for additional clinics and further training for members of the nursing team. The plans for additional clinics would reduce the need for patients to travel. We saw other plans for improvements in patient focus, IT, practice staff and the environment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Policies and procedures we looked at had not been regularly reviewed or updated.

The practice held monthly governance meetings. We looked at minutes from the last meetings and found that performance, quality and risks had been discussed. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and clinical lead meetings and action plans were produced to maintain or improve outcomes. The practice had arrangements for identifying, recording and managing risks. We saw that risks were regularly discussed at team meetings. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented for example the infection control audit. However the risks identified during our inspection around the dispensary services had not been identified by the practice.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the GP lead for medicine management. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at the monthly team meetings and practice meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy, and management of sickness which were in place to support staff. Not all policies were up to date and current. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice planned to re-establish the patient participation group (PPG) in 2015. The practice manager showed us the analysis of the last national patient survey published in July 2014 which covered both the Suttons Medical Group practices. The patient survey showed 70 % of respondents would recommend this surgery to someone new to the area. The CCG regional average was 82%. The practice will look to undertake its own in-practice patient surveys to provide further feedback regarding the services they provide.

The practice had taken action to address the areas from the survey with a new IT upgrade. Staff feedback regarding what could be better managed within the practice was fairly limited, although all mentioned the recent IT change to EMIS Web. Staff said they felt that this could have been better managed with more training on the new system, as they were at times struggling with the changes. Staff told us they felt involved and engaged in the practice to improve outcomes for patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that appraisals were due to take place which included a personal development plan with the new practice manager. Staff told us that the practice was very supportive of training. Nurses told us group clinical supervisions had stopped but hoped they would resume with new clinicians in post.

Appropriate policies and procedures were available. We saw, however, that the policies and procedures were not

Are services well-led?

Good

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

routinely or regularly reviewed and updated. Several of the policies we looked at contained outdated information. We found the practice had a draft whistleblowing policy in place, but staff did not have access to this.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients.