Sleaford Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Sleaford Medical Group on 13 April 2017.

Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because some systems and processes in place were not effective to keep them safe. For example, patient safety alerts, monitoring of patients on high risk medicines, medication reviews, monitoring of the cold chain and management of patients with urinary tract infections.
- Risk were assessed and well managed.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, learning and dissemination in relation to significant events and complaints was not always effective.
- The practice had a system in place to keep patients safe and safeguarded from abuse. However some staff were not up to date with safeguarding training.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The July 2016 national patient survey results had not been reviewed and actions put in place to improve the areas of concerns identified by the patients registered at the practice.
- Most of the national patient survey results from July 2016 were below national and CCG average results.
- Comments cards we reviewed told us that patients said they were treated with compassion, dignity and respect. They felt cared for, supported and listened to.
- The practice did not have an active patient participation group and there was limited evidence to demonstrate that they proactively sought feedback from patients and staff.
- The practice had a number of policies and procedures to govern activity, but some were overdue a review.

Summary of findings

- There was no overarching governance framework in place to support the delivery of the strategy and good quality care.
- There was a documented leadership structure but it was not clear who took overall responsibility for the surgery.

The areas where the provider must make improvements are:

- Improve the process in place for the management of risks to patients and others against inappropriate or unsafe care. This should include: patient safety alerts, monitoring of patients on high risk medicines, medication reviews, monitoring of the cold chain and management of patients with urinary tract infections.
- Ensure pathology results are reviewed to ensure action is taken where appropriate and they are filed on the patient record in a timely manner.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Gather patient views and experiences to ensure the services provided reflect the needs of the population served.
- Review the systems and processes in the dispensary to ensure they are effective.
- Ensure there is leadership capacity to deliver all the improvements.
- Develop ways to monitor and improve patient satisfaction.
- Consolidate the complaints process and ensure learning from complaints are discussed and shared. Ensure trends are analysed and action is taken to improve the quality of care as a result.
- Formalise meetings with staff to support staff feedback and maintain records of discussions with actions agreed upon.

In addition the provider should:

- Review procedures for carrying out regular balance checks of controlled drugs
- Ensure safeguarding registers are updated and actions documented in regard to children who do not attend for hospital appointments.
- Ensure all staff have completed safeguarding training relevant to their role.

I am placing this service in special measures. Where a service is rated as inadequate for one of the five key questions or one of the six population groups and after re-inspection has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we place it into special measures.

Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Patients were at risk of harm because some systems and processes in place were not effective to keep them safe. For example, in the areas of patient safety alerts, monitoring of patients on high risk medicines, medication reviews, monitoring of the cold chain and management of patients with urinary tract infections.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- The Practice had a system in place for reporting, recording and monitoring significant events. However this was not always operated effectively. In some cases the record did not always document learning, changes implemented or whether a review was needed. There was no evidence of themes being identified.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. Staff demonstrated that they understood their responsibilities and most staff had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Requires improvement

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

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average. The practice acknowledged that it was it was their highest achievement to date and had regular fortnightly meetings to keep updated.
- There was no evidence to suggest that staff were aware of current evidence based guidance.
- The practice did not have a programme of continuous audits to monitor quality and to make improvements.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- There was no evidence of a system for clinical supervision for nurses working in extended roles such as minor illness and injury or as a nurse prescriber.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care. 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 70% of patients said the last GP they spoke to was good at treating them with care and concern compared to CCG average of 82% and national average of 85%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 82%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice ran an Urgent Care centre which provided seven day access.
- At this inspection we reviewed patient feedback from the July 2016 patient survey results. We found that 21 areas out of 23

Summary of findings

were below CCG and national average. Only 25% of patients who responded told us they usually get to see or speak to their preferred GP compared to the CCG average of 60% and national average of 59%.

- 33% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.
- 45% of patients said they usually had to wait 15 minutes or less after their appointment time to be seen compared to CCG average of 67% and national average of 65%.
- Since June 2016 there was a designated person responsible for handling complaints. However the practice did not have an on-going overview of complaints received and there was no formal method of identifying themes or trends in complaints raised.
- Patients could get information about how to complain in a format they could understand. However, there was limited evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

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

- Although the partners were positive about future plans, we found a lack of leadership and governance relating to the overall management of the service. The practice was unable to demonstrate strong leadership in respect of safety.
- There was a limited governance framework which supported the delivery of the strategy and good quality care. For example, patient safety alerts, monitoring of patients on high risk medicines, medication reviews, monitoring of the cold chain and management of patients with urinary tract infections, significant events, incidents and learning from complaints.
- There was a documented leadership structure and most staff felt supported by management but at times they were unavailable and so staff were unsure who to approach with issues.
- The provider had some awareness of the requirements of the duty of candour but the systems and processes in place did not always support this.
- The practice did not have an active patient participation group and there was limited evidence that the practice were proactive in seeking feedback from staff and patients which were acted upon.

Summary of findings

- The practice had a number of policies and procedures to govern activity. Most had been reviewed but some still required an update.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

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

However we did see some examples of good practice:

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 86.2% which was 2.3% above the CCG average and 3.3% above the national average. Exception reporting was 3.6% which was 0.5% above the CCG average and 0.3% below national average.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- The practice did not consistently carry out structured annual medicine reviews for older patients.
- Since the last inspection the practice had employed a practice care co-ordinator. Their role enabled them to make decisions based on patient assessments and create or alter care plans based on individual needs. We were told that 1814 personalised care plans were now in place.

People with long term conditions

Inadequate

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

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

However we did see some examples of good practice:

Summary of findings

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 94.2% which was 3.2% above the CCG average and 2.9% above the national average. Exception reporting was 3.8% which was 0.7% below the CCG average and 1.7% below national average.
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that included an assessment of asthma, was 76.7% which was 1.1% below the CCG average and 4.7 % above the national average. Exception reporting was 3.1% which was 1.1% below the CCG average and 4.8% below national average.
- The percentage of patients with COPD who had a review, undertaken by a healthcare professional was 93.2% which was 0.5% above the CCG average and 3.6% above the national average. Exception reporting was 7% which was 1.7% below the CCG average and 4.5% below the national average.
- The practice did not have an effective system to recall patients for a structured annual review to check their health and medicines needs were being met.

Families, children and young people

Inadequate

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

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

However we did see some examples of good practice:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 81% which was comparable with the CCG average of 82% and the national average of 81%.

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

Summary of findings

The practice ran a minor injury service seven days a week.

- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- Reception staff were responsible for tracking pregnancy and birth of children. This meant that births that were not registered with the practice within 4 weeks would receive a follow up letter asking them to do so. The practice would then invite the new babies into the practice and arrange vaccinations.

Working age people (including those recently retired and students)

Inadequate

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

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

However we did see some examples of good practice:

- The needs of these populations 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 and access to the urgent care centre at weekends.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, sexual health.
- The practice sent text message reminders of appointments and test results.

People whose circumstances may make them vulnerable

Inadequate

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

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

However we did see some examples of good practice:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

Summary of findings

- 89% of patients with a learning disability hadin the last 12 months.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

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

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

However we did see some examples of good practice:

- 90% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months which is comparable to the national average.
- 96% of patients who had schizophrenia, bipolar affective disorder and other choses had had a comprehensive care plan documented in the last 12 months which was comparable to the national average.
- The practice told us that 60% of patients experiencing poor mental health had received an annual physical health check.
- The practice told us that 93% of patients who experienced depression had received an annual physical health check in the last 12 months.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

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

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016.

The practice results were below local and national averages for 21 out of 23 questions. 225 survey forms were distributed and 118 were returned. This represented 0.6% of the practice's patient list.

- 52% of patients found it easy to get through to this practice by phone compared to the CCG average of 75% and national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 86% and national average of 85%.
- 77% of patients described the overall experience of this GP practice as good compared to the CCG average of 85% and the national average of 85%).
- 66% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 75% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards which were all positive about the standard of care received. 22 were positive. The service was described as excellent with staff who are friendly, caring and respectful. All the patients felt listened too and were treated with dignity and respect. From the seven negative comments the common themes were appointments which ran late and availability of a preferred GP. These were discussed with the management team at feedback.

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

Areas for improvement

Action the service MUST take to improve

- Improve the process in place for the management of risks to patients and others against inappropriate or unsafe care. This should include: patient safety alerts, monitoring of patients on high risk medicines, medication reviews, monitoring of the cold chain and management of patients with urinary tract infections.
- Ensure pathology results are reviewed to ensure action is taken where appropriate and they are filed on the patient record in a timely manner.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Gather patient views and experiences to ensure the services provided reflect the needs of the population served.
- Review the systems and processes in the dispensary to ensure they are effective.
- Ensure there is leadership capacity to deliver all the improvements.
- Develop ways to monitor and improve patient satisfaction.
- Consolidate the complaints process and ensure learning from complaints are discussed and shared. Ensure trends are analysed and action is taken to improve the quality of care as a result.
- Formalise meetings with staff to support staff feedback and maintain records of discussions with actions agreed upon.

Summary of findings

Action the service SHOULD take to improve

- Review procedures for carrying out regular balance checks of controlled drugs
- Ensure safeguarding registers are updated and actions documented in regard to children who do not attend for hospital appointments.
- Ensure all staff have completed safeguarding training relevant to their role.

Sleaford Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP Specialist Advisor, 2nd CQC inspector, a member of the CQC medicine management team, a practice nurse specialist advisor and a practice manager specialist advisor.

Background to Sleaford Medical Group

Sleaford Medical Group provides primary medical services to approximately 18,500 patients. It covers Sleaford and surrounding villages. The practice has a dispensary which dispenses medicines to patients registered with the practice.

At the time of our inspection the practice employed four partners (three male, one female), one salaried GP's (female), two locum GPs, one HR & Business Manager,one nurse supervisor, five minor illness nurses, seven health care assistants, one practice co-ordinator, one patient liaison officer, two reception supervisors, 11 medical receptionists, one dispensary manager, four dispensers, four dispensary assistants,16 administration and data quality staff and one handyman.

The practice is a training practice and on the day of the inspection had one GP clinical fellow and four GP trainees. GP trainees are qualified medical practitioners who receive specialist training in General Practice.

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

Sleaford Medical Group is open from 8.30 to 6.30pm. Appointments were available from 8.40 to 11.10am and 3.40pm to 5.50pm on weekdays.

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

Sleaford Medical Group also provides an urgent care service weekends and Bank Holidays which opens from 8.00am to 6.00pm. This service is also available from 6.30pm to 8pm Monday to Friday. On arrival, patients are assessed and the injury treated by a trained nurse or doctor as appropriate. However in some cases it may be necessary to refer patients on to further treatment at a hospital. This service is available to patients whether or not they are registered with a GP, and can provide care for those not living in Sleaford or the surrounding area. The unit can care for patients attending with both minor illnesses and injuries and is a walk in service. The patients' own GP will receive a summary of the care received following the consultation so their notes can be updated accordingly. Any patient who cannot be treated will be referred as appropriate.

The practice is located within the area covered by NHS SouthWest Lincolnshire Clinical Commissioning Group (SWLCCG).

Detailed findings

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

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

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

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

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, NHS England, Health watch and the CCG to share what they knew. We carried out an announced visit on 13 April 2017. During our visit we:

- Spoke with a range of staff (GP partners, nursing staff, practice management, dispensary and administrative staff).
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

The Practice had a system in place for reporting, recording and monitoring significant events. However this was not always operated effectively.

Prior to our inspection we requested information about significant events in the previous 12 months. We were sent a summary of significant events covering the year 2016. On the day of our inspection staff we spoke with explained the process for reporting a significant event and told us they would complete a significant event form or inform their line manager of an event. We saw there was a significant event policy and procedure which had been reviewed in January 2017 and which provided guidance for staff.

We reviewed a number of records of significant events and found that in some cases the record did not always document learning, changes implemented or whether a review was needed. There was no evidence of themes being identified. Although we did see that some incidents had been discussed at some meetings, there was not always evidence of identified actions having been implemented and a lack of consistency in learning from incidents being shared with staff. For example a significant event in October 2016 related to an oxygen cylinder being empty when it was needed. The learning was identified as the cylinder was not actually empty and training would be given on how to use the cylinder. The practice had not identified how this was going to be implemented or who was responsible for it.

We were told that details of significant events and outcomes were available on the practice intranet including meeting minutes but some staff we spoke with found it difficult to find this information. Some staff did tell us that they had been sent information regarding incidents relevant to them via the practice intranet. We asked for information that related to any incidents from January to April 2017 but it was not readily available or accessible to staff.

We found that the practice did not have an effective system in place to ensure patient safety alerts were received, disseminated and actioned appropriately. Several examples of alerts that had not been actioned included patients on a medicine to reduce cholesterol that was contra-indicated with another medicine or patients of child bearing age who had been prescribed a medicine for epilepsy with limited information recorded regarding reviews.

The practice was unable to evidence that all staff were aware of any relevant alerts to the practice and where they needed to take action.

There was no system in place to carry out an audit in response to patient safety alerts. For example, there was no process to review old patient safety alerts to see if any new patients were affected. There was no clear system for the storing of patient safety alerts for future reference. The practice had a safety alerts policy in place which provided clear guidance for staff but on the day of the inspection we found that this had not been adhered to.

Since the inspection the practice have reviewed and updated the system and have told us regular monthly searches will be undertaken and actioned where appropriate.

Overview of safety systems and processes

During our inspection we found some systems, processes and practices in place to keep people safe and safeguarded from abuse.

- We looked at the arrangements the practice had in place in regard to safeguarding people against abuse. Policies were accessible to all staff and reflected relevant legislation and local requirements. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. We saw that the practice had regular safeguarding meetings. However, the practice could not demonstrate if any action had been taken when children on the safeguarding register did not attend for hospital appointments
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and most had received training on safeguarding children and vulnerable adults relevant to their role. Substantive GPs and practice nurses were trained to child protection or child safeguarding level three. However we found that the long term locum GPs did not have current safeguarding training and the have health care assistants had only been trained to level one.

Are services safe?

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene. However some issues were found in relation to infection prevention and control,

- We observed the premises to be clean and tidy. The practice employed an external cleaning company. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC policy in place and staff had received regular training.
- The practice had undertaken an infection control audit in April 2017. Areas of improvement had been identified but at the time of the inspection they had not had time to put together an action plan to address the minor improvements identified as a result.
- We found that Control of Substances Hazardous to Health (COSHH) data sheets were last reviewed on 20 March 2015. Some staff we spoke with were not aware of where to find these sheets should they need to refer to them for guidance.
- We found that the practice had a schedule in place to clean the ear irrigation equipment. However it was not clear who was responsible for the cleaning or if it was cleaned at the end of each day. The practice did not have a policy in place to provide guidance to staff.
- We reviewed a sample of sharps bins and found that not all were signed, labelled and dated as per national guidance.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).
- The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. There was a named GP responsible for providing leadership to the dispensary team. We saw records showing all members of staff involved in the dispensing process had received appropriate training, annual appraisals and regular checks of their competency. A barcode checking system was in place giving additional dispensing accuracy assurance.
- We were shown standard operating procedures (SOPs) which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines), and there was a system in place to ensure staff had read and understood them. Prescriptions were signed before being dispensed and there was a process in place to ensure this occurred.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard; access to them was restricted and the keys held securely. However, balance checks of controlled drugs had not been carried out regularly, and this was not covered in the SOP. Since the inspection the practice told us they have reviewed and updated the systems and processes in place in the dispensary.
- Expired and unwanted medicines were disposed of according to waste regulations. There was a procedure in place to ensure dispensary stock was within expiry date, however staff did not always record when checks were made. Staff told us about procedures for monitoring prescriptions that had not been collected, however we found five prescriptions which had not been removed in accordance with the practice SOP. There was a protocol in place for the management of repeat prescriptions, however we saw staff had issued prescriptions which were past their review date which was contrary to the practice SOP. In addition, we found almost a quarter of patients on regular repeat medicines had not had a medicines review recorded in the past 12 months.

Inadequate

Are services safe?

- Staff did not keep a 'near-miss' record (a record of errors that have been identified before medicines have left the dispensary). We saw dispensing errors which had reached patients were appropriately recorded and these were discussed at practice meetings, and learning shared to prevent recurrence. Dispensary staff responded appropriately to medicines recalls from suppliers and we saw records of the action taken in response to these. However, we found national patient safety alerts, for example those from the Medicines and Healthcare products Regulatory Agency (MHRA), were not always actioned.
- We checked the medicines refrigerator in the dispensary and found temperatures had not been recorded on three days in March and one day in April 2017. In addition, temperatures had been recorded which were outside of the recommended range for storing medicines, and no action had been recorded in response to this.
- The practice kept blank computer prescription forms and pads securely, and there was a system in place to track their use in accordance with national guidance.
- We checked the system in place for the management of high risk medicines, which included regular monitoring in accordance with national guidance. We found the system was not effective and did not protect the health and safety of patients on these high risk medicines. For example, we reviewed electronic patient records and we found 31 patients had not received appropriate blood monitoring and no alert was in place to ensure prescribers had a full record of medicines a patient was being given.

  After the inspection we sent the practice a letter with a specific request for more detailed information in a number of areas, including the management of high risk medicines. The practice responded to the request about a number of medicines that were either considered high risk or were contraindicated in combination with other drugs to decide whether they were practicing safely. Since the inspection the practice have reviewed all the patient records and amended their systems to ensure blood monitoring is completed before medicines are prescribed. They told us they had contacted all the patients whose tests were outstanding and asked them to attend for a medication review.
- We saw that the practice were designated a Yellow Fever Centre by the National Travel Health Network and Centre (NaTHNaC). However the guidance provided for staff was dated 2008. This meant that the practice were not following the NaTHNaC Code of Practice for Yellow Fever Vaccination Centres 2016 which stated that staff who administer the vaccines have up to date policies to ensure they are kept up to date with current guidance.
- The process in place for medicines reviews was not effective. Large numbers of medicines reviews were shown as being completed by inappropriate staff as well as large numbers of patients showing they had not had medicines reviews. For example, the practice's electronic records system indicated that 842 medicines reviews had been carried out by Health Care Assistants. 4389 patients on repeat prescriptions were showing as not having had medication reviews within the last 12 months. After the inspection the practice reviewed and made changes to their system however this needs time to be embedded and become effective.
- We found reception staff triaged patients with suspected urinary infections and dispensary staff subsequently issued them with prescriptions for antibiotics without the clinical oversight of an appropriate prescriber. There was no history taking or examination recorded and kidney function was not checked. Dispensary staff made choices about which antibiotic to issue, as well as the course length, however there was no written policy or training in place for this extended role.
- We checked medicines stored in the treatment room, including three medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We checked the recording logs for all three medicine refrigerators within the main practice. Refrigerator temperature checks were carried out on a daily basis to ensure that medicine was stored at the appropriate temperature. However when we checked the records we found the temperatures in all three refrigerators had gone above the recommended level of eight degrees Celsius on at least 34 occasions. The practice were unable to evidence what action, if any, had been taken on any of these occasions. All three fridges were calibrated and had received a yearly portable appliance test. After the inspection the practice contacted Public Health England and the medicine

manufacturers to ask if any immediate action was required. Since the inspection the practice have reviewed this process and put measures in place to ensure daily temperature checks are carried out and when they are above the recommended temperature actions are taken to ensure the integrity and quality of the medicines were not compromised. Staff had also received further training.

- We saw that the practice cold chain policy which provided guidance to staff which was due for review in January 2017. We found that not all staff followed the guidance to ensure that medicine was stored at the appropriate temperature.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise but there was no evidence to suggest what mentorship and support they received from the medical staff for this extended role.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately. On one occasion we found a nurse had administered prescription only medicines to a patient without an appropriate direction from a prescriber.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS process.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There was a health and safety policy available. A general risk assessment had been undertaken by an external company in September 2015. Recommendations were made but it was not clear if all of these had been completed. However the practice have sent the CQC further evidence which was not shown to the inspection team on the day of the inspection. A further risk assessment had been carried out in November 2016 and the practice had completed most of the actions. This will be followed up at the next inspection.
- The practice had a fire risk assessment carried out on 5 April 2017. This assessment recommended that the practice had a five year Electrical Installation Condition Report (EICR) and improvements to its emergency lighting. The EICR report was one of the recommendations from a previous risk assessment in July 2014. On the day of the inspection the practice were unable to show us that these had been completed. A fire drill had been carried out on the 12 April 2017 and there were four designated fire wardens within the practice. Further training was planned for 8 June 2017 to increase the number to 10.
- There was a fire evacuation plan in place which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Water temperature monitoring checks were carried out on a monthly basis as per recognised legionella management guidelines.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw evidence that a rota system to ensure adequate staffing levels were maintained to meet the needs of patients. However some staff we spoke with said that busy times there were not enough staff available.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Inadequate

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises with adult and child defibrillator pads. Oxygen was also available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive continuity and recovery plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians told us they were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- We did not see any evidence documented that systems were in place to keep all clinical staff up to date.
- Meeting minutes we looked at did not contain discussions on NICE guidance and from sample records we looked at we found that the practice did not monitor these guidelines.

Management, monitoring and improving outcomes for people

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

The most recent published results for 2015/16 were 99% of total points available. The practice were 3.3% above the CCG and 3.7% above national averages. Exception reporting was 6.6% which was 1.5% below CCG average and 2.2% below national averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients were unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for QOF (or other national) clinical targets. Data from 2015/16 showed;

For example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 94.2% which was 3.2% above the CCG average and 2.9% above the national average. Exception reporting was 3.8% which was 0.7% below the CCG average and 1.7% below national average.
- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months that included an assessment of asthma was 76.7% which was 1.1% below the CCG average and 4.7 % above the national average. Exception reporting was 3.1% which was 1.1% below the CCG average and 4.8% below national average.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 86.2% which was 2.3% above the CCG average and 3.3% above the national average. Exception reporting was 3.6% which was 0.5% above the CCG average and 0.3% below national average.
- The percentage of patients with COPD who had a review, undertaken by a healthcare professional was 93.2% which was 0.5% above the CCG average and 3.6% above the national average. Exception reporting was 7% which was 1.7% below the CCG average and 4.5% below the national average.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 92.2% which was 2.8% above the CCG average and 8.5% above the national average. Exception reporting was 7.9% which was 2.9% above the CCG average and 1.1% above the national average.

There was some evidence of quality improvement including clinical audit.

- We were sent three audits to review prior to the inspection. All were completed audits where the improvements made were implemented and monitored. However the practice did not have a programme of continuous audits to monitor quality and to make improvements. The audits we reviewed were from one GP partner. No other evidence was sent prior to or since the inspection.
- The practice had completed an audit cycle on returned medication in the dispensary. The practice had identified actions to take which included leaflets and posters in the dispensary to inform patients of this problem. These actions were planned to be completed by June 2017.
- We looked at the practice prescribing rates in relation to selected antibiotics prescribed from December 2013 to September 2016. The practice scored 1.26 which was higher than the CCG target of 1.16 and higher than the CCG actual target of 1.050.
- The practice had positive results in respect of referrals to secondary care. They were below CCG and national

averages. For example:- Ear nose and throat the practice referral rate was 0.12 compared to a CCG average of 0.16 and national average of 0.15. Gastroenterology the practice referral rate was 0.39 compared to a CCG average of 0.63 and national average of 0.95. Gynaecology the practice referral rate was 0.16 compared to a CCG and national average of 0.22.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. For example diabetes, asthma and COPD.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines under patient group directions could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. However we found that the guidance for staff in regard to yellow fever immunisations was dated 2008.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. However there was no evidence of a system for clinical supervision for nurses working in extended roles such as minor illness and injury or as a nurse prescriber.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. For example, customer care training.

Coordinating patient care and information sharing

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

- We found the practice had employed a practice care co-ordinator since we last inspected in May 2015. Their role enabled them to make decisions based on patient assessments and create or alter care plans based on individual needs.
- Sleaford Medical Group was a host practice for the Sleaford Neighbourhood Team. They worked with health and social care organisations across Sleaford and Grantham. It brought together health and social care professionals which included GPs, community nurses, social workers, community psychiatric nurses and therapists to meet the needs of an ageing population and transform the way that care was provided for people with long-term conditions.
- From evidence we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. However we found that the practice did not have a system in place to ensure that the referral had been received and the patient had received an appointment.
- On the day of the inspection we found the procedure for the review of pathology results, action where appropriate and updating the patient record was not effective. 46 abnormal blood results had been received from 8 March 2017 to 6 April 2017. Theyhad been reviewed but it was not clear if they had been actioned and the results had not been filed in the patient electronic record.
- Staff worked together with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record.
- Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Requires improvement

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- Consent was recorded in care plans completed by the practice care co-ordinator.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and referral to in-house physiotherapists.
- The practice's uptake for the cervical screening programme was 81% which was comparable with the CCG average of 82% and the national average of 81%. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice had carried out an audit from January to December 2016 and the practice were within the recommended guidelines for inadequate smears of 1.67%. Further support and training had been offered to staff whose percentage was higher than the national average.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. 62.6% of patients eligible had attended for bowel cancer screening which was above the CCG average of 61 % and national average of 58%.
- 78% of patients eligible had attended for breast cancer screening which was above the CCG average of 77% and national average of 73%.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/ national averages. For example, rates for the vaccines given to under two year olds ranged from 91% to 97% and five year olds 94%.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

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

We had 29 patient Care Quality Commission comment cards completed. 22 were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comments highlighted that staff responded compassionately when they needed help and provided support when required. . From the seven negative comments the common themes were appointments which ran late and availability of a preferred GP. These were discussed with the management team at feedback.

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

Results from the national GP patient survey showed that the practice were below average for all of its satisfaction scores in July 2016 results in respect of care and compassion,

For example:

- 81% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 77% of patients said the GP gave them enough time compared to the CCG average of 85% and the national average of 87%.
- 94% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 70% of patients said the last GP they spoke to was good at treating them with care and concern compared to CCG average of 82% and national average of 85%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.
- We spoke with the management team who was not aware of the current national patient survey data and had not reviewed it and put actions in place.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey in July 2016 showed that patient satisfaction with their involvement in planning and making decisions about their care and treatment were below local and national averages for consultations.

Results from the July 2016 national GP patient survey showed the results were below CCG and national average. For example:

- 81% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average and national average of 86%.
- 66% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 82%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

Comments cards we reviewed told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff.

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

Requires improvement

Are services caring?

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas in three different languages informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 217 patients as carers (1.17% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Information on what to do in times of bereavement was available in the waiting room and on the practice website.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours on a Tuesday, Wednesday and Thursday evening until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- A TV screen in the waiting room provided information to patients.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. For example, information in a number of other languages.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.40 to 11.10am and 15.40 to 17.50pm. Extended hours appointments were offered on a Tuesday, Wednesday and Thursday evening until 8pm for working patients who could not attend during normal opening hours.

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

Sleaford Medical Group also provided an urgent care service weekends and Bank Holidays which opened from 8.00am to 6.00pm. This service was also available from 6.30pm to 8pm Monday to Friday. On arrival, patients were assessed and the injury treated by a trained nurse or doctor as appropriate. However in some cases it was necessary to refer patients on to further treatment at a hospital. This service was available to patients whether or not they were registered with a GP, and could provide care for those not living in Sleaford or the surrounding area. The unit could care for patients attending with both minor illnesses and injuries and was a walk in service. The patients' own GP would receive a summary of the care received following the consultation so their notes could be updated accordingly. Any patient who could not be treated would be referred as appropriate.

In addition to pre-bookable appointments that could be booked up to three to four weeks in advance, urgent appointments were also available for patients that needed them.

The results of the national patient survey in July 2016 showed patients were not happy with the responsiveness of the service. For example:

- 76% of patients were satisfied with the practice's opening hours compared to CCG and national average of 76%.
- 52% of patients found it easy to get through to this practice by phone compared to the CCG average of 75% and national average of 73%.
- 25% usually get to see or speak to their preferred GP compared to the CCG average of 60% and national average of 59%.
- 95% of patients said their last appointment was convenient compared with the CCG average of 94% and the national average of 92%.
- 65% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 33% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 59% and the national average of 58%.
- 45% of patients said they usually had to wait 15 minutes or less after their appointment time to be seen compared to CCG average of 67% and national average of 65%.

We spoke with the management team who was not aware of the current national patient survey data and had not reviewed it and put actions in place.

Comments cards we reviewed aligned with these views in relation to time waiting to be seen and getting an appointment with a preferred GP.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had a triage system in place. The reception team followed a protocol which allowed for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person for handling complaints in the practice. We saw that information was available in the reception area to help patients understand the complaints system which included information about advocacy services to support patients through the process of raising an NHS complaint. The procedure was also available on the practice website.

Prior to our inspection we had received concerns from members of the public and stakeholders regarding both verbal and written complaints not being responded to and a lack of availability of the staff member responsible for complaints to discuss matters with them. We discussed this with the HR and Business Manager who told us some complaints from the first half of 2016 had not been responded to within timescales. They had identified this as an issue and appointed a Patient Liaison officer in June 2016 who was responsible for dealing with verbal and written complaints made to the practice. They were usually readily available to speak to patients who wished to raise a concern or make a complaint and this meant patients concerns or complaints could often be resolved immediately. The Patient Liaison officer kept a comprehensive record of all verbal as well as written complaints and we found that the complaints they had dealt with had been responded to in a timely and appropriate way.

We found there were three folders of complaints. One contained the complaints made prior to the Patient Liaison Officer taking up post, another folder held complaints made in 2016 prior to their appointment and a third contained complaints made through NHS England.

Prior to our inspection we had asked to see a summary of all complaints received in the last 12 months. The summary provided did not include all the complaints in all the folders which meant the practice did not have an ongoing overview of complaints received and there was no formal method of identifying themes or trends in complaints raised. Furthermore the Patient Liaison Officer did not have access to or knowledge of the complaints made through NHS England. Following our inspection the practice provided us with an updated spreadsheet which contained all the complaints. The HR and Business Manager told us that going forward the Patient Liaison Officer would manage complaints received through all sources to maintain an overview.

Learning from complaints was not always identified or where it was identified in some cases there was no evidence of responsibility for following up learning points and limited evidence of discussion. There was no annual review of complaints. A high number of complaints related to one GP partner and we were told that this theme had been identified but there was no documentation to evidence this or details of proposed actions to address this.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting area but not all staff we spoke with knew and understood the values.

Governance arrangements

We found the practice had limited governance arrangements in place to support the delivery of their strategy. There was a lack of effective systems in place to monitor quality and make improvements, limited arrangements for identifying and managing risks and an unstructured approach to dealing with significant events.

We found:-

- Patients were at risk of harm because some systems and processes in place were not effective to keep them safe. For example, in the areas of patient safety alerts, monitoring of patients on high risk medicines, medication reviews, monitoring of the cold chain and management of patients with urinary tract infections.
- Risks to patients were assessed and well managed.
- There was a documented staffing structure and that most staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, specialist interests in substance misuse, family planning, women's health, dermatology, minor surgery, infection control.
- Practice specific policies were implemented and were available to all staff. Most had been updated and reviewed regularly. We found that some were overdue for review in January 2017, for example, cold chain and consent. We also found that not all staff followed the guidance. For example, cold chain, significant events and complaints.
- We also found that the nursing team did not have a protocol in place for injectable medicines and spillage of bodily fluids. The practice did not have a programme of continuous audits to monitor quality and to make improvements.

Leadership and culture

We found that overall leadership was not effective. Although the practice was positive about future plans, we found a lack of accountable leadership and governance relating to the overall management of the service. The practice was unable to demonstrate strong leadership in respect of safety.

The practice had some awareness of the duty of candour however some of the systems and processes in place were not effective and did not ensure compliance with the relevant requirements. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

There was a documented leadership structure but it was not clear who took overall responsibility for the surgery. Not all staff we spoke with felt supported or valued by all the partners in the practice and felt management were not always visible or effective.

We saw and we were told that there had been a large changeover of nursing staff over the past two years. However on the day of the inspection we saw that the team supported each other to carry out their roles and responsibilities.

We were told that the practice held a variety of meetings which included those for partners, department heads, nursing team, dispensary, reception and significant event meetings. There were no specific clinical meetings and limited evidence of clinical discussion in the partners meeting minutes. On the day of our inspection we asked to see minutes of nurses meetings but none were available. Full practice meetings did not take place but we were told by the senior partner that these were going to be introduced going forward. Some of the meetings did not have set agendas and minutes were limited. Therefore it was difficult to identify what had taken place, what actions and learning had been shared and who was responsible for actions and a timeframe.

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

The practice had limited evidence to demonstrate that they encouraged and valued feedback from patients and staff.

- On the day of the inspection we found that the practice did not have an active patient participation group (PPG). The member of the PPG we spoke with told us that the PPG was in a period of transition as some of the group

Are services well-led?

Inadequate

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

members had resigned and the HR and Business Manager was in the process of advertising for more people to join the group. We asked to look at minutes of meetings and found that these dated back to 2015.

- The July 2016 national patient survey results had not been reviewed and actions put in place to improve the areas of concerns identified by the patients registered at the practice.
- The practice had completed a small patient survey from January to March 2017. An action plan had been put in place and some actions had already been completed and some were in progress. The action plan did not identify who was responsible for the actions and a date by which they should be completed.
- We reviewed the practice data for NHS Family and Friends (FFT). 90% of patients who completed the FFT in November and December 2016 were extremely likely to recommend the practice. 86% in January 2017 were extremely likely to recommend the practice.
- Staff told us they all took part in 'Fruit Friday' where all staff joined together for lunch.
- We saw that the practice were proactive and keen to ensure that staff received training relevant to their role and where appropriate upskilled staff to enable them to carry out new roles.

Continuous improvement

There was limited evidence of continuous improvement.

The practice was a training practice and they had one GP clinical fellow and four GP trainees. GP trainees are qualified medical practitioners who receive specialist training in General Practice.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users.** **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to ensure that systems and processes were established and operated effectively.** **The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others.** **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**