Lakeside Healthcare Stamford

Quality Report

The Sheepmarket Surgery
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Lincs
PE9 1YA
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Sheepmarket Surgery on 2 February 2015 followed by a further comprehensive inspection on 6 April 2017.

The overall rating for the practice was Good but we rated the Safe domain as requires improvement. The full comprehensive report from 2 February 2015 and focussed follow-up inspection from 6 April 2017 can be found by selecting the 'all reports' link for The Sheepmarket Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection on 19 September 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspections of 2 February 2015 and 6 April 2017. This report covers our findings in relation to those requirements.

The rating for the Safe Domain is good and the overall rating for the practice remains as Good.

Our key findings were as follows:

- We found that the practice had made considerable improvements since the last inspection.
- An effective system was in place for safeguarding service users from abuse.
- We found the practice had made significant improvements to its system for significant events, near misses and incidents. Some further improvement was required to ensure that all events were captured and investigations were detailed and actions identified and implemented.
- The practice now had systems in place to minimise risks to patient safety which included fire safety and monitoring of Disclosure and Barring Checks for all staff including the medicine delivery drivers.
- A review of some of the processes in the dispensary had taken place to minimise the risk to patients. For example, regular checks to ensure that dispensary stock is within expiry date and maintain appropriate records and implemented a system to ensure dispensary fridge temperatures were recorded daily in line with national guidance.
- Quality Improvement had taken place but in relation to clinical audit, further information was required to evidence the actions, outcomes and shared learning achieved as a result of the audits.

Summary of findings

- We saw a more formalised process had been put in place for meetings that took place in the practice. Most minutes of meetings we reviewed were structured and followed a fixed agenda.
- The practice now had a governance framework in place which supported the delivery of their strategy and good quality care.

The provider should:

- Continue to review the system in place for significant events to ensure all events are captured , investigations are detailed, actions are identified and implemented
- To strengthen the system for clinical audits to demonstrate the evidence, actions, outcomes and shared learning achieved.
- Review the process in place for prescriptions that remain uncollected in the dispensary to ensure patient safety.

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.

- There was a much improved system in place for reporting and recording significant events, incidents and dispensary near misses. The policy and reporting form had been updated. We reviewed a number of events and found that most were recorded, investigated and reviewed in a consistent manner. However the system still needed further work in terms of the detail in some of the investigations, consideration on the impact for the patient and a review to ensure all actions had been completed. Meeting minutes represented the discussion that took place.
- Arrangements for safeguarding reflected relevant legislation and local requirements.
- Risks to patients were now assessed and well managed. For example, Fire safety and Disclosure and barring checks for all staff.
- Processes in the dispensary had been reviewed, for example, regular checks to ensure that dispensary stock is within expiry date and maintain appropriate records and implemented a system to ensure dispensary fridge temperatures were recorded daily in line with national guidance. However we found that the process for uncollected prescriptions needed a review to ensure patient safety.
- We reviewed the process in place for quality improvement which included clinical audit. We could see that a lot of work had taken place but further information was required to evidence the actions, outcomes and shared learning achieved as a result of the audits.
- We saw a more formalised process had been put in place for meetings that took place in the practice. Most minutes of meetings we reviewed were structured and followed a fixed agenda.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Continue to review the system in place for significant events to ensure all events are captured , investigations are detailed, actions are identified and implemented
- To strengthen the system for clinical audits to demonstrate the evidence, actions, outcomes and shared learning achieved.
- Review the process in place for prescriptions that remain uncollected in the dispensary to ensure patient safety.

Lakeside Healthcare Stamford

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was led by a CQC Lead Inspector. The team included a GP specialist adviser.

Background to Lakeside Healthcare Stamford

The Sheepmarket Surgery provides primary medical services to approximately 14,200 patients.

The Sheepmarket Surgery is purpose built with consultation rooms on the ground floor. Administration and meeting rooms were on the upper floor. The practice offered a full range of primary medical services and was able to provide dispensary services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.

At the time of our inspection the practice employed eight GP partners, two salaried GP and one locum GP. Five GPs were full time (four male and one female) and six part-time (four female and two male). The surgery also employed a practice manager, four practice nurses, two health care assistants and assistant practice manager, finance manager, seven receptionists, five dispensers and five administration staff.

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

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

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

The Sheepmarket Surgery, Ryhall Road, Stamford, Lincs. PE9 1YA

The practice was open from 8am until 6.30pm Monday to Friday. The practice had extended hours on Tuesday and Thursday 6.30pm to 8pm and Saturday's 8am until 11am.

Patients can book appointments in advance and the practice also offer book on the day appointments. Patients who do not have an appointment but feel they need to be seen will be triaged by the on-call team (one GP and one minor illness nurse) and given advice by telephone, brought to the surgery to be seen on the day or given an appointments where appropriate

The practice had a website which we found had an easy layout for patients to use. It enabled patients to find out a wealth of information about the healthcare services provided by the practice. Information on the website could be translated in many different languages. This enabled patients whose first language was not English to read the information provided by the practice.

The Sheepmarket Surgery 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.

Detailed findings

The Sheepmarket Surgery is one of three surgeries in Stamford who merged with Lakeside Healthcare on 1 July 2016. The three practices are now known as Lakeside Stamford. At the time of the inspection the Care Quality Commission continued to have further discussions with Lakeside Healthcare in regard to their registration with the Care Quality Commission following the merger in 2016.

Why we carried out this inspection

In February 2015 we had carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. That inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. At that inspection we found the practice requires improvement overall but specifically the rating for providing a safe and well led service. We carried out this further comprehensive inspection to ensure that sufficient improvement had been made.

At the inspection on 6 April 2017 we found that the practice had made significant improvements but still needed to improve the system in place for significant events and quality improvement activities such as clinical audit. The Care Quality Commission recognised the improvements already made and no additional enforcement action was taken. We gave the practice a further requirement notice for Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.

We carried out this follow up inspection at the practice to check that further improvements have been made.

How we carried out this inspection

During our visit we:

We spoke with the registered manager, practice manager, chief nursing officer, safeguarding lead nurse and members of the dispensary team.

We reviewed policies and procedures relating to the clinical and general governance of the service.

Good

Are services safe?

Our findings

At the inspection on 2 February 2015 we rated the practice as requires improvement for providing safe services as the practice were unable to demonstrate a safe track record over the long term. At that inspection we found that the practice did not have processes in place to prioritise safety, identify risks and improve patient safety such as a process to learn from significant events near misses or complaints. The practice did not have a risk log and had not carried out assessments to identify risks and improve patient safety. The practice did not have an effective system in place to ensure appropriate actions were taken in response to safety alerts. At the inspection on 6 April 2017 we found significant improvements had been made but further work was required in respect of significant events, fire safety, safeguarding and some processes within the dispensary.

These arrangements had significantly improved when we undertook a follow up inspection on 19 September. The practice is now rated as good for providing safe services.

Safe track record and learning

- At the inspection in February 2015 we found the system the practice had in place for reporting, recording and monitoring of significant events was not clear or consistent.

  In April 2017 we found there was an improved system in place for reporting of significant events. Some had been reviewed in a timely manner but the system still required some improvement. Significant events still varied in terms of documentation, investigations, actions and learning. We were able to review minutes of meetings where these were discussed but they were not detailed or easy to follow. Lessons were shared to make sure actions were taken to improve safety to patients but these needed to be evidenced more clearly. Significant events were a standing item on meeting minutes we reviewed. Themes and trends had been identified at the time of the inspection these but had not been discussed or shared with staff.

  At this recent inspection we found there was an improved system in place for reporting of significant events. A log was kept of significant events, actions, when to be completed by and where and when learning outcomes had been discussed. Significant events were discussed at practice meetings and minutes of these were shared with all staff in order that those not able to attend the meeting were included in the learning. Significant events were a standing item on most meeting minutes we reviewed.

  The practice had 17 on the log since April 2017 to current date.

  We reviewed seven in detail and found that most were recorded, investigated and reviewed in a consistent manner. However the system still needed to be further work in terms of the detail in some of the investigations, consideration on the impact for the patient and a review to ensure all actions had been completed. We discussed this with the management team who intend to further review this area of the significant event process. In meeting minutes we reviewed we found three examples of an event that should have been considered a significant event. For example, from a complaint regarding incorrect patient information on electronic patient record, reporting a sudden death to the coroner and use of disused email address by a secondary care provider. Going forward the practice plan to review meeting minutes to ensure that any significant events are captured from discussions that have taken place.

- At the inspections in February 2015 and April 2017 we found that most of the arrangements for safeguarding reflected relevant legislation and local requirements. In April 2017 we found that the safeguarding registers needed an update to ensure that they were current and contained the relevant alerts. We also found that there was limited attendance at the practice multi-disciplinary team meetings by health visitors and midwives.

  At this inspection we found that the practice now had effective systems, processes and practices in place to keep patients safe and safeguarded from abuse. Since the last inspection the practice had merged with Lakeside Healthcare who had a dedicated safeguarding team. The safeguarding team covered all the practices within Lakeside Healthcare and worked in partnership with countywide professionals.

- At the inspection in April 2017 we found that staff routinely checked stock medicines were within expiry date and fit for use, and there was an SOP to govern this activity. However, we checked the dispensary stock and found an item which had expired in January 2017.

Good

Are services safe?

Dispensary staff told us about procedures for weekly monitoring of prescriptions that had not been collected. However, we found several uncollected prescriptions which were greater than six weeks old, one from November 2016 which had not been followed up in accordance with the standard operating procedure.

At this inspection we found that the dispensary staff were able to show clear documentation of regular fridge temperature checking. The documentation also had clearly annotated sections where the fridge was out of, or close to, the expected range of 2-8 degrees, for example, on one occasion it was noted that the fridge was being re-stocked when the temperature recorded was 10.4 degrees and on a second occasion it was recorded at 11.3 degrees due to refrigerator not being reset properly. The practice manager immediately completed a significant event form for irregularities in the cold chain in the dispensary and this will now be processed through the significant event investigation process in order to identify learning and actions for the future.

Dispensary staff were able to show clear documentation of monthly refrigerator stock checks of medications which were signed and dated by the person completing the check. The stock checking was completed by dispensary staff only and included checking if medicines were in date.

In relation to uncollected prescriptions we found that further work was required as the practice had not considered contacting the patient if a prescription had not been collected within a six week time frame. We spoke with the management team who told us they would review this process and discuss with other practices within Lakeside Healthcare.

- At the inspection in April 2017 we found that the practice used volunteer drivers to transport medicines from the dispensary to patient's homes but did not have a written protocol which outlined what the drivers would do with undelivered medicines. We also found that the drivers had not had a disclosure and barring service (DBS) check carried out.

  At this inspection we found the volunteer driver now had a DBS in place and the practice had put a system in place to monitor Disclosure and Barring Checks for all staff.

- At the inspection in February 2015 and April 2017 we found the system the practice had in place to demonstrate quality improvement, for example, clinical audits, was not effective. Clinical audits had taken place but there was limited evidence in some of the audits we looked at that demonstrated where improvements had been implemented, monitored and showed improvement in patient outcomes.

  At this inspection we reviewed the quality improvement process at the practice. We saw that the practice had an audit calendar in place. We reviewed five clinical audits and found improvements had been made in the audit documentation to evidence improvements in patient outcomes. However we spoke with the management team who acknowledged that more work was still required to evidence the actions, outcomes and shared learning achieved as a result of the audits. Since the last inspection the practice had merged with Lakeside Healthcare. We spoke with the chief nursing officer who now had responsibility for the Quality Assurance Framework which included clinical improvement and audit. Quality Improvement would be reviewed by the executive board across the whole of Lakeside Healthcare to ensure improvement in patient outcomes was demonstrated and shared across the whole organisation.

- At the inspection in April 2017 we found that practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. However in meeting minutes we looked at we saw limited evidence of the sharing and learning in a number of areas, for example, significant events, complaints, safeguarding and NICE guidance.

- At this inspection we found a more formalised process had been put in place for meetings that took place in the practice. Most minutes of meetings we reviewed were structured and followed a fixed agenda which included areas such as significant events, complaints and NICE guidance.

Monitoring risks to patients

Risks to patients were now assessed and well managed.

- At the inspection in April 2017 we found that the practice had an up to date fire risk assessment and carried out regular fire drills. However there were no designated wardens within the practice. We were told

Good

Are services safe?

and we saw in the fire safety policy that senior members of the team took responsibility for this role should a fire occur. We spoke with the management team and advised that they should consider having fire wardens due to the complex layout of the building.

At this inspection we found the practice now had an effective system in place for fire safety. The fire safety policy had been reviewed and updated. Four fire wardens were now in place and fire drill and fire safety meeting had taken place to review the drill and ensure that any identified actions had been completed.