Sleaford Medical Group

Quality Report

Riverside Surgery,
47 Boston Road,
Sleaford,
Lincs.
NG34 7HD
Tel: 01529 303301
Website: www.sleafordmedicalgroup.co.uk

Date of inspection visit: 27 September 2017
Date of publication: 31/10/2017

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of this practice on 13 April 2017.

Breaches of legal requirements were found in relation to governance arrangements within the practice. We issued the practice with a warning notice requiring them to achieve compliance with the regulations set out in those warning notices by 24 August 2017.

Summary of findings

We undertook this focused inspection on 27 September 2017 to check that they now met the legal requirements. This report only covers our findings in relation to those requirements.

At the inspection on 27 September we found that not all the requirements of the warning notice had been met.

Our key findings across the areas we inspected for this focussed inspection were as follows:

- The practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe. Further work was required in regard to significant events, medicine reviews including high risk medicines and complaints.
- Safe systems were now in place for patient safety alerts, monitoring of the cold chain and the management of patients with a suspected urinary tract infection (UTI).
- Improvements had been put in place in regard to governance arrangements and some of the appropriate steps required had been taken to ensure patients remained safe.
- The leadership structure had strengthened considerably and areas of responsibility had been identified. There was an updated documented leadership structure and it was clear who took overall responsibility for the surgery.

As the legal requirements of the warning notice were not met the Care Quality Commission has sent the practice a letter of concern in which we require them to send us fortnightly action plans.

The areas where the provider must make improvements are:-

- Continue to review the system in place for significant events to ensure all events are captured, investigations are detailed, actions are identified and implemented.
- Further improve the process in place for the management of risks to patients and others against inappropriate or unsafe care. This should include: medication reviews and the monitoring of patients on high risk medicines,
- Further 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.

In addition the provider should:

- Ensure there is leadership capacity to deliver all the improvements

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?

- We found the practice had made improvements to its system for significant events, near misses and incidents but the system required further development to evidence that all events were captured, fully investigated, learning identified and actions implemented.
- The system in place for ensuring patient safety alerts were received and actioned appropriately was now effective.
- Considerable improvements had taken place in regard to the system for patients who required a medication review however further work was required to achieve the 80% target set by the practice since the last inspection.
- Most patients on high risk medicines had been reviewed. We found most patients had alerts on the clinical system and blood monitoring had taken place. However the practice needed to ensure, patients received the correct monitoring for the medicine and that monitoring carried out by other organisations is updated on the patient's clinical record.
- The practice had reviewed and updated the system and process for the management of the cold chain and it was now effective.
- Patients who presented at the practice with a suspected urinary tract infection (UTI) were now managed in accordance with evidence based guidance and with appropriate clinical oversight.

Are services responsive to people's needs?

- At this inspection we found that the practice had taken some steps to address the issues with the complaints system but this was still work in progress. The practice had reviewed their complaints process and identified the weaknesses in their systems but had not yet implemented the necessary improvements required. They needed to further consolidate the complaints process and ensure learning from complaints were discussed and shared. Ensure trends were analysed and action was taken to improve the quality of care as a result.

Are services well-led?

- At this inspection we found that the practice had made improvements to their governance arrangements and had

Summary of findings

taken some of the appropriate steps required to ensure patients remained safe. However further work was required in regard to significant events, medicine reviews including high risk medicines and complaints.

- At this inspection we found that the leadership had strengthened considerably and areas of responsibility had been identified. There was an updated documented leadership structure and it was clear who took overall responsibility for the surgery.
- The provider had awareness of the requirements of the duty of candour but some of the systems and processes in place still did not support this.

Summary of findings

Areas for improvement

Action the service MUST 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.
- Further improve the process in place for the management of risks to patients and others against inappropriate or unsafe care. This should include: medication reviews and the monitoring of patients on high risk medicines,
- Further 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.

Action the service SHOULD take to improve

- Ensure there is leadership capacity to deliver all the improvements

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, a second CQC inspector, a CQC inspector in training and a member of the CQC medicine management team.

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), three salaried GP's (female), two locum GPs, one HR & Business Manager, one nurse supervisor, four nurses, six health care assistants, one practice care co-ordinator, one patient liaison officer, two reception supervisors, 11 medical receptionists, one dispensary manager, four dispensers, five dispensary assistants, 17 administration and data quality staff and one handyman.

The practice is a training practice and on the day of the inspection had five 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 8.30am to 6.30pm. Appointments were available from 8.40am 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 8am to 6pm. 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).

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

On 13 April 2017 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Breaches of legal requirements were found in relation to governance arrangements within the practice. We issued the practice with a warning notice requiring them to achieve compliance with the regulations set out in the warning notice by 24 August 2017.

We undertook an announced focussed inspection of Sleaford Medical Group on 27 September 2017. This inspection was carried out to check that improvements to meet legal requirements in respect of the warning notice planned by the practice after our comprehensive inspection on 13 April 2017 had been made.

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, Healthwatch and the SouthWest Lincolnshire CCG to share what they knew. We carried out an announced visit on 27 September 2017.

During our visit we:-

Spoke with the Registered Manager, senior GP partner, practice manager and members of the administration and dispensary team.

Spoke with six patients and observed how patients were being cared for in the reception area.

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

Are services safe?

Our findings

At the comprehensive inspection in April 2017 we rated the practice as inadequate for providing safe services as the arrangement in place for the assessment of risks to the health and safety of service users who received care or treatment were not effective.

We issued a warning notice in relation to Regulation 17 of the Health and Social Care Act 2008 in relation to significant event analysis, patient safety alerts, medicine reviews monitoring of patients on high risk medicines, monitoring of the cold chain, management of patients with urinary tract infections and complaints.

Safe track record and learning

At the inspection in April 2017 we found that the Practice had a system in place for reporting, recording and monitoring significant events. However this was not always operated effectively.

At this recent inspection we found there was an improved system in place for reporting of significant events however further work was required to ensure the system was effective.

Prior to our inspection we requested information about significant events. We were sent a log of significant events (SEA) and the practice had recorded 37 significant events since 1 January 2017. Each SEA had a unique number, was categorised by specific department and details were kept of review dates, actions and where and when events had been discussed. There was not a clear process to record actions taken in respect of each significant event. We found that the log did not include all incidents that had occurred and which may have been deemed significant clinical events. For example, missed referrals to secondary care.

We looked at 10 significant events which the practice had recorded since the last inspection.

We found significant events varied in terms of documentation, investigations, actions and learning. It was difficult to see if they had been investigated and reviewed sufficiently to ensure relevant learning and improvement could take place.

Significant events were a standing item on meeting minutes we reviewed. Minutes of these meetings we looked at we found 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 did not attend' (DNA) letter in regard to a urinary clinic was not processed as per the practice policy. The learning identified was that staff should adhere to the policy. The practice had identified that the coders needed some further training but had not stated how or when this would take place or who was responsible for it. In the significant event meeting minutes for 18 September 2017, this significant event had been discussed but had limited information recorded and no information on further training for the coders had been documented. Clinical coders are responsible for making a full and accurate computer record of a patient's attendance at a GP practice or a stay in hospital.

We were sent the annual review of significant events for 2016-17 in which themes, trends and severity of risk had been identified. However the report did not detail discussions that had taken place, actions identified or person responsible for carrying them out.

We were told and the practice staff showed us that details of significant events and outcomes were available on the practice intranet including meeting minutes. Staff were able to read and review significant events raised in regard to their own department. These were then discussed at their team meetings.

We saw there was a significant event policy and procedure which had been reviewed in January 2017. Further detail was required to provide further guidance for relation to themes and trends analysis and significant event meetings which were now held every two months.

At our previous inspection in April 2017, we found the system for ensuring patient safety alerts were actioned appropriately was not effective or embedded in the practice. During this inspection, we checked to see what improvements had been made. The safety alerts protocol had been reviewed in January 2017, which set out the procedure for dealing with received alerts. We checked three examples of recent safety alerts and found staff had followed the protocol; copies of the alert were saved on the computer system and sent to all relevant staff. We reviewed meeting minutes which demonstrated alerts were discussed regularly and appropriate actions were taken in response. The practice also had a system in place to

Are services safe?

continually check for patients affected by alerts by running searches on the clinical system. Identified patients were brought to the attention of a GP and appropriate action was taken.

Overview of safety systems and processes

- At our previous inspection in April 2017, we found the process in place for medicines reviews was not effective and large numbers of patients had not had a medicine review within the last 12 months. During this inspection, we checked to see what improvements had been made. The practice had carried out two audits in April and September 2017 which showed an improvement from 36% to 64% of patients having had a medicine review within the previous 12 months. On the day of our inspection, this had increased to 68% against the 80% target set by the practice since the last inspection. We also reviewed meeting minutes which showed progress was regularly reviewed against practice targets. However, when we reviewed patients requiring a medicine review who were taking high risk medicines, we found details of treatments prescribed in secondary care were not always recorded on the clinical system. This meant some patients had not received the correct monitoring and there was a risk medicines reviews may be ineffective because the doctor was not aware of all the medicines the patient was taking. In addition, we found when monitoring had been carried out by other organisations, results had not been updated on the patient's clinical record.
- In April 2017, we found the process in place for the management of patients who presented with a suspected urinary tract infection (UTI) was not effective or the system in place did not work as intended. Patients were being triaged by non-clinical staff and antibiotics were supplied by dispensary staff without appropriate clinical oversight. At this inspection, we found an updated protocol was in place, which had been reviewed in May 2017. The protocol stated that patients would be seen by the duty doctor, and that all prescriptions would be signed by the doctor to ensure safety and quality. We reviewed seven patient records and found in all cases they had been managed in accordance with the practice policy and with appropriate clinical oversight.
- In April 2017, we found there was no effective system in place to ensure that monitoring of the cold chain across the whole practice was being managed in accordance with national guidance. In addition, where breaches of the cold chain had occurred, staff had not taken appropriate action to follow them up. At this inspection, we found policies and standard operating procedures had been reviewed and all staff had signed to confirm they had read and understood them. Medicines and vaccine fridge temperatures were checked in accordance with national guidance and temperatures recorded on an electronic document management system. In addition, the practice had implemented a system using data loggers to give additional assurance. Where temperatures had been recorded which were outside the recommended range, we found staff had taken appropriate action.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At the comprehensive inspection in April 2017 we rated the practice as requires improvement for providing responsive services as the arrangement in place for responding to people's needs and listening and learning from concerns and complaints were not effective.

We issued a warning notice in relation to Regulation 17 of the Health and Social Care Act 2008 which included complaints.

Listening and learning from concerns and complaints

At our inspection in April 2017 we found that the practice did not have an effective system for dealing with complaints. At this inspection we found that the practice had taken some steps to address the issues with the system but this was still work in progress. The practice had reviewed their complaints process and identified the weaknesses in their systems but had not yet implemented the necessary improvements required.

There was still some information 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. However the practice were not acting in accordance with the procedure they displayed. For example, complaint forms were not available to patients without having to ask at reception for them.

In the time between our inspection in April 2017 and this inspection we had received concerns from members of the public about complaints not being responded to and lack of availability of the practice manager to speak to in respect of complaints. We discussed this with the practice manager and they told us that as part of restructuring they were going to be at the practice full time and would be responsible for dealing with complaints. The senior GP partner and the practice manager had recently attended a training course in relation to complaints.

We found that the complaints system was still disjointed and inconsistent. There was an electronic log of complaints but some of the complaints we reviewed were not included in the log. Therefore the practice still did not have an ongoing overview of complaints received. When complaints were received they were not given a unique identifier. This meant that although we saw that complaints were now discussed on a weekly basis at the management meeting, it was not clear which complaints had been discussed or added to the meeting action log. There was not a clear process to record actions taken in respect of each complaint. The practice manager told us they had designed a new complaint form which had not yet been introduced. We were told that this would enable actions relating to each complaint to be recorded and monitored and the outcome and learning identified. The practice also planned to rate each complaint according to impact and severity.

The practice had carried out an analysis of complaints from 2016-2017 in order to provide a comparison between departments and types of complaints. However the results were not representative as it was based on the information on the log which did not include all complaints.

We reviewed 24 complaints and found in some cases there was no evidence that the complaint had been acknowledged or responded to, investigations and responses were not detailed enough and sometimes inappropriate or not made in a timely manner. We saw that some complaints had been responded to and closed before the investigation was complete. Additionally, in two of the complaints we reviewed both should have also been considered as significant events. At our inspection in April 2017 we found that there was a high number of complaints relating to a specific member of staff. At this inspection we were told this had been addressed and saw that there had been no further complaints recorded about them.

Are services well-led?

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

Our findings

At the comprehensive inspection in April 2017, we rated the practice as inadequate for providing well-led services as we found that arrangements to improve the quality and safety of services provided required significant improvements in oversight and monitoring of governance arrangements.

We issued a warning notice in relation to Regulation 17 of the Health and Social Care Act 2008 in relation to the governance arrangements in place for significant event analysis, patient safety alerts, medication reviews monitoring of patients on high risk medicines, monitoring of the cold chain and management of patients with urinary tract infections and complaints.

At this inspection we found that the practice had made improvements and had taken some of the appropriate steps required to ensure patients remained safe. However, as the legal requirements of the warning notice were not met the Care Quality Commission have sent the practice a letter of concern in which we require them to send us fortnightly action plans in respect of significant events, medicine reviews including high risk medicines and complaints.

Governance arrangements

At the inspection in April 2017 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.

At this inspection we found that the practice had made improvements to their governance arrangements and had taken some of the appropriate steps required to ensure patients remained safe. However we found that further work was required.

At this inspection we looked at specific areas in relation to patient safety. For example, in the areas of significant events, patient safety alerts, medicine reviews and patients on high risk medicines, monitoring of the cold chain, management of patients with urinary tract infections and complaints,.

We found:-

There was an updated process in place for the reporting, recording and monitoring of significant events and incidents. However when we looked at 10 of the significant events in detail we found that the investigation, documentation of the investigation, initial findings, learning and follow-up was still not effective. We reviewed weekly management meetings from 7 August 2017 to 11 September 2017 and found that the practice had 23 missed Referrals. The practice had not considered these as significant events and no process had been put in place to reduce the risk of this happening in the future.

The system for the monitoring of patient safety alerts which also included Medicine and Healthcare products Regulatory Agency (MHRA) and National Institute for Health and Care Excellence (NICE) had been reviewed and updated. The safety alerts protocol had been reviewed and meeting minutes we reviewed demonstrated alerts were discussed regularly and appropriate actions were taken in response.

The system for patients who required a medicine review and, in some cases a high risk medicines review, had been updated and in most cases appropriate monitoring and reviews had been completed in accordance with best practice guidance. Two audits relating to medicines reviews had been completed in April and September 2017. However, further work was required in regard to patients who took high risk medicines where we found details of treatments prescribed in secondary care were not always recorded on the clinical system and when monitoring had been carried out by other organisations, results had not been updated on the patient's clinical record.

We found that improvements had been made and the practice could now demonstrate that the integrity and quality of medicines within the vaccine refrigerators were not compromised.

The management of patients who presented with a suspected urinary tract infection (UTI) were now managed in accordance with the practice policy and in records we reviewed we found they had appropriate clinical oversight.

We found that the practice had reviewed the system in place for handling complaints and concerns but it was still not effective. The practice were unable to demonstrate that people's concerns and complaints were listened and responded to and used to improve the quality of care.

Are services well-led?

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

Leadership and culture

At our inspection in April 2017 we found a lack of leadership and governance relating to the overall management of the service and at the time the practice was unable to demonstrate strong leadership.

At this inspection we found that the leadership had strengthened considerably and areas of responsibility had been identified. There was an updated documented leadership structure and it was clear who took overall responsibility for the surgery.

At our inspection in April 2017 we found the practice held a variety of meetings which included but we found that there were no specific clinical meetings and limited evidence of clinical discussion in the partners meeting minutes. 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.

At this inspection we found that there was a comprehensive schedule of meetings planned and we saw details were kept on the practice computer system. These included meetings for partners, department heads, nursing team, dispensary, reception and significant event meetings. There were clear agendas and the minutes showed what had been discussed and who was responsible for any required actions. However the detail within the minutes needed further information to ensure discussions and actions were clearly documented.

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

We spoke with six patients on the day of the inspection. Five of the six patients told us that they received a good service, that staff were friendly and professional, referrals to other providers were done in a timely manner and they would recommend the practice to friends and relatives. Patient's also expressed two negative themes which were getting an appointment and waiting time to be seen were a theme expressed by those we spoke with.

At our previous inspection we found we found that the practice did not have an active patient participation group (PPG).At this inspection we spoke with the new PPG chairperson who told us they had recently been appointed to the role and looked forward to working with the management team and the PPG to explore different ways of gathering feedback from patients and working with the practice to improve services.

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 all the systems and processes identified in the warning notice were established and operated effectively. The provider had not assessed, monitored and mitigated the risks for all the areas identified in the warning notice that related to the health, safety and welfare of service users and others. This was a continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.