Dr Azmeena Nathu

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Azmeena Nathu, Pennygate Health Centre on 19 October 2017. Overall the practice is rated Inadequate.

We had previously inspected the practice in February 2015 where they received a overall rating of Good.

From this inspection our key findings across all the areas we inspected were as follows:

- A leadership structure was in place but there was insufficient leadership capacity and limited governance arrangements in place
- 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, safeguarding, medicine reviews, monitoring of patients on high risk medicines, monitoring of the cold chain, recruitment and retention of staff, NICE guidance and meeting minutes. 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 and trends being identified or learning shared with staff. On the day of the inspection we could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment.
- Risks to patients were assessed but the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, fire, legionella and clinical equipment.
- Feedback from people who use the service and stakeholders was positive. 34 patients expressed high levels of satisfaction about all aspects of the care and treatment they received. The feedback from comments cards we reviewed said patients felt they were treated with care, compassion, dignity and respect.
- The practice did not have a robust system in place to monitor the training of the GPs and staff within the practice.
- Comments cards we reviewed told us that patients were positive about their interactions with staff and said they were treated with compassion and dignity.

Summary of findings

The areas where the provider must make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. In particular, patient safety alerts, safeguarding, medicine reviews, monitoring of patients on high risk medicines, monitoring of the cold chain, recruitment and retention of staff, fire safety, legionella, electrical safety and portable appliance testing, NICE guidance, staff training, shared learning from significant events and complaints and meeting minutes.
- Gather patient views and experiences to ensure the services provided reflect the needs of the population served.
- Ensure there is leadership capacity to deliver all improvements.

The areas where the provider should make improvement are:

- Complete yearly reviews of themes and trends for significant events and complaints.
- Improve the current processes in place for the monitoring of repeat prescriptions and referrals to secondary care.
- Ensure staff who undertake chaperone duties have a Disclosure and Barring Certificate.
- Arrange infection control training for the lead nurse.
- Ensure all staff have received Mental Capacity awareness training.
- Review the Electrical Installation Condition Report (EICR) recommendations for improvement and ensure where appropriate these have been completed.
- Review the information technology system in place to ensure it is fit for purpose.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of 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 to varying the terms of their registration within six months if they do not 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, patient safety alerts, safeguarding, medicine reviews, monitoring of patients on high risk medicines, monitoring of the cold chain, recruitment and retention of staff, NICE guidance.
- 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 and trends being identified or learning shared with staff.
- Risks to patients were assessed but the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, fire, legionella and clinical equipment.
- On the day of the inspection we could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment.
- Staff demonstrated that they understood their responsibilities and most staff had received training on safeguarding children and vulnerable adults relevant to their role.
- We reviewed personnel files and found that there were inconsistencies and gaps in the recruitment checks undertaken prior to employment. We also found that the practice did not have effective systems in place in respect of recruitment of locum staff.
- 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.
- There was no evidence to suggest that staff were aware of current evidence based guidance.

Summary of findings

- Clinical audits demonstrated quality improvement.
- The practice could not demonstrate role-specific training, for example, for reviewing patients with long term conditions and no updates for dispensers once they had obtained their NVQ2 qualification.
- The practice did not have an effective system in place to monitor training. Therefore we could not be assured that staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff told us they had received an appraisal in the last 12 months.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs and end of life care was coordinated with other services involved.

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.

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, the principal GP would do visits to care homes early morning to avoid interruption at meal times.
- Data from the July 2017 national GP patient survey showed patients rated the practice lower than others for most aspects of care. For example, 82% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 91%.
- 70% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.
- 85% 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%.
- 69% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 86%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- Comments cards we reviewed told us that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.

Summary of findings

- 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. We found good access to appointments for both GPs and the nursing team. We reviewed access to appointments and found good availability for on the day and next day appointments. Appointments were also bookable up to six months in advance The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients can access appointments and services in a way and at a time that suits them.
- Comments cards we reviewed told us that patients found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- At this inspection we reviewed patient feedback from the July 2017 patient survey results. We found that 21 areas out of 23 were below CCG and national averages. For example, 60% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 71%. 65% of patients said that the last time they wanted to speak to a GP they were able to get an appointment compared with the CCG average of 63% and the national average of 56%. 65% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Pennygate Patient Link. For example, self-checking facility and TV screen so that patients can see when they are called for their appointment.
- 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.

Summary of findings

Are services well-led?

Inadequate

The practice is rated as inadequate for providing a well-led service.

- 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.
- Although the principal GP was 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, safeguarding, medicine reviews, monitoring of patients on high risk medicines, monitoring of the cold chain, recruitment and retention of staff, NICE guidance, staff training, learning from significant events and complaints and meeting minutes.
- The arrangements in place for managing risks were not effective.
- The practice could not demonstrate that they proactively sought feedback from staff and patients, which it acted on. The patient participation group known as Pennygate Patient Link was active.
- The provider had some awareness of the requirements of the duty of candour but some of the systems and processes in place did not always support this.
- On the day of the inspection the information technology system in place was not fit for purpose as staff were unable to retrieve documents from an external drive.
- The practice had a number of policies and procedures to govern activity.
- There was little innovation or service development. There was also minimal evidence of learning and reflective practice.

Summary of findings

The six population groups and what we found

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

Older people

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

- There was not a clear process for recording staff training so we were unable to see if all staff had completed safeguarding training. Therefore we were not assured that 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 were commissioned for the enhanced service for avoiding unplanned admissions and had identified 11% of the most vulnerable patients registered with the practice and had care plans in place.
- 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) is 150/90 mmHg or less was 93.2% which was 6.7% above the CCG average and 7.3% above the national average. Exception reporting was 3% which was 0.1% below the CCG average and 0.9% below national average.
- The Pennygate Patient Link offered transport for older people to attend appointments at the practice. They also offered emotional and bereavement support in times of need and ran social activities not only for patients registered with the practice but also for those in the community.

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.

Summary of findings

- The principal GP was the named GP for the patients registered at the practice however the process in place for medicines reviews was not effective. Dispensary staff had no role in determining when a patients' medication review was due. As there was not system in place it was not clear how a patient would be alerted to a need for a review. The GP told us that she knew her patients well and would request people to attend for review when she signed prescriptions.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 96.4% which was 2.9% above the CCG average and 5.1% above the national average. Exception reporting was 2.4% which was 2.1% below the CCG average and 3.1% below the national average.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that includes an assessment of asthma was 100% which was 22% above the CCG average and 24.4% above national average. Exception reporting was 0.5% which 2.6% below the CCG average and 7.4% below national average.
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional was 95.5% which was 1.8% above the CCG average and 5.9% above the national average. Exception reporting was 15.4% which was 7.6% above the CCG average and 3.9% above the national average.

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.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above to CCG/national averages. For example, rates for the vaccines given to under two year olds and five year olds was 100%.
- The practice's uptake for the cervical screening programme was 76%, which was below the CCG average of 84% 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 told us they worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. However we did not see any documented evidence of the discussion took place.

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).

- We found good access to appointments for both GPs and the nursing team. We reviewed access to appointments and found good availability for on the day and next day appointments. Appointments were also bookable up to six months in advance
- 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.

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.

- The practice offered longer appointments for patients with a learning disability.
- 95% of patients with a learning disability had had their care reviewed in the last 12 months.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- 95 % of patients on the palliative care register had received a review in the last 12 months.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations which included the Pennygate Foundation.

Summary of findings

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).

- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months which was above the CCG and national average.
- 94% 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 with the CCG average and above the national average.
- The practice told us that 75% 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 which included the Pennygate Foundation.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2017. 272 survey forms were distributed and 115 were returned. This represented a 42% response rate and 3.23% of the practice's patient list. Most of the results from the survey were well below the CCG and national averages.

- 60% of patients found it easy to get through to this practice by phone compared to the CCG average of 74% and the national average of 71%.
- 70% 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 88% and the national average of 84%.
- 71% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and the national average of 85%.
- 60% 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 82% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all extremely positive about the standard of care received. Patients who completed these cards said the service provided was excellent. Staff were professional, friendly, compassionate and respectful and friendly. They took the time to listen and were very understanding. They also said that staff responded compassionately when they needed help and provided support when required.

We spoke with staff from three local care homes who told us they were very satisfied with the overall service provided by Pennygate Health Centre. They described the staff as professional and approachable and the GP was always respectful and took time to listen to the patient and to the care staff. They had a negative comment in relation to prescriptions from the dispensary with some taking between seven to fourteen days to be completed.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. In particular, patient safety alerts, safeguarding, medicine reviews, monitoring of patients on high risk medicines, monitoring of the cold chain, recruitment and retention of staff, fire safety, legionella, electrical safety and portable appliance testing, NICE guidance, staff training, shared learning from significant events and complaints and meeting minutes.
- Gather patient views and experiences to ensure the services provided reflect the needs of the population served.
- Ensure there is leadership capacity to deliver all improvements.

Action the service SHOULD take to improve

- Complete yearly reviews of themes and trends for significant events and complaints.
- Improve the current processes in place for the monitoring of repeat prescriptions and referrals to secondary care.
- Ensure staff who undertake chaperone duties have a Disclosure and Barring Certificate.
- Arrange infection control training for the lead nurse.
- Ensure all staff have received Mental Capacity awareness training.
- Review the Electrical Installation Condition Report (EICR) recommendations for improvement and ensure where appropriate these have been completed.

Summary of findings

- Review the information technology system in place to ensure it is fit for purpose.

Dr Azmeena Nathu

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, two members of the CQC medicines team and a practice manager specialist adviser.

Background to Dr Azmeena Nathu

Dr Anzeema Nathu, Pennygate Health Centre, is a GP practice and is located in the South Lincolnshire town of Spalding and has 3,460 patients at the 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.

The practice is situated amongst the 20% of the most deprived neighbourhoods in the country. Within the practice population there was clear evidence of deprivation, particularly associated with migrant workers and their families. Both male and female life expectancy were comparable with the national average. The age distribution of people living in the South Lincolnshire Clinical Commissioning Group area is an area that reflects that of the national profile. The age profile of the practice showed that there was a higher percentage of younger patients and 8% aged 75 or over. 18% of the patient list were of non-British nationality, being predominantly Eastern European.

The practice has one principal GP (female), two locum GPs (male), one practice nurse, two members of staff who have dual roles as dispensers / administrators. There are two receptionists and a cleaner who is employed directly by the practice.

The practice offered a full range of primary medical services and was able to provide dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises

The practice is located over two floors, though all areas accessed by patients were located on the ground floor.

Pennygate Health Centre were open from 8am to 6.30pm Monday to Friday.GP Appointments were from 8.45am to 11am and 3.30pm to 5.30pm Monday to Friday.

In addition to pre-bookable appointments that could be booked up to six months in advance,

the practice had extended hours on a Tuesday evening from 6.30pm to 8.30pm.

The practice lies within the NHS South Lincolnshire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours 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 and the South Lincolnshire CCG (SLCCG) to share what they knew.

We carried out an announced visit on 19 October 2017.

During our visit we:

- Spoke with a range of 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 living 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. For example: 2016/17.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was not an effective system for reporting and recording significant events.

Prior to our inspection we requested information about significant events in the previous 12 months. The practice sent us pre-inspection information and three significant events had been identified. The system in place needed further work in terms of consideration on the impact for the patient and a review to ensure all actions had been completed. We were able to review minutes of meetings but did not see any evidence that these were discussed, learning shared and themes and trends had not been identified. Since the inspection the practice sent us further information and have completed a themes and trends analysis but the meeting minutes still did not evidence what lessons were shared to make sure actions were taken to improve safety to patients.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (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).
- We saw that dispensary staff reported and recorded significant events and we saw two that related to the dispensary. These were appropriately reported and investigated with learning shared. We were told that near misses were handled as significant events although there were no examples available to view on the day of the inspection.
- We found that the practice did not have an effective system in place to ensure patient safety alerts were received, disseminated and actioned appropriately. There was no log of alerts received and no clear evidence of how they had been shared and actioned. Several examples of alerts that had not been actioned included risk of suicide from a hair loss medicine, the recall of certain batches of an anti-coagulant medicine and a certain brand of diabetic insulin pen. 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.

Overview of safety systems and processes

During our inspection we found that the systems, processes and practices in place to keep people safe and safeguarded from abuse were not effective.

- On the day of the inspection we could not establish if the practice had an effective system in place to safeguard service users from abuse and improper treatment. There was a lead GP for safeguarding. Staff we spoke with were aware who the lead GP was. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a system in place to identify vulnerable adults on their patient record. There were no safeguarding multi-disciplinary meetings held by the practice or minutes of any meetings that had taken place in regard to safeguarding discussions.
- At the time of the inspection there was no children on the at risk register, looked after children or under a child protection plan.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. GP's were trained to safeguarding Level three but we did not see any evidence that the practice nurse had safeguarding training Level two.
- A notice in the clinical rooms and waiting room advised patients that chaperones were available if required. We found that staff who acted as chaperones were trained for the role and had not 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). Since the inspection two further members of staff had DBS certificates in place.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules in place we were told monitoring took place but this was not documented.

Inadequate

Are services safe?

- On the day of the inspection we were told that the GP and the administrator were infection control leads but had not completed any infection control lead training. The practice had liaised with the local infection prevention teams to find out dates for training so that staff could keep up to date with best practice. Since the inspection most staff had completed on-line infection control training but link practitioner training for the lead nurse was still outstanding.
- There was an infection prevention and control protocol but the practice could not evidence that all staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

Not all the arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, dispensing, security and disposal).

- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Records showed that all members of staff involved in the dispensing process were appropriately qualified but the practice did not support them to keep up to date. We were told that competence was checked regularly by the GP through observation and questioning.
- The standard operating procedures (SOPs) seen in the dispensary did not include enough detail to guide staff although the dispensers were able to give detailed information that assured us safe practice was maintained. Since the inspection the practice had commenced the process to review and update all the SOPs to provide further guidance to staff. We have since received further evidence in regard to SOPs and these will be reviewed when we carry out a further inspection.
- We saw processes in place in the dispensary to check medicines were in date and stored appropriately. Records showed dispensary fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature and staff were aware of the procedure to follow in the event of a fridge failure.
- Dispensary Medicine Reviews (DRUMS) were completed by the GP as the dispensary staff told us they were not trained to conduct these reviews with patients.
- Systems were in place to ensure prescriptions were signed before the medicines were dispensed and handed out to patients. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. We spoke with staff from three care homes who told us that their requests for repeat prescriptions were not always received in a timely manner and it could take between one to two weeks for them to be received.
- On the day of the inspection we found that the practice did not have an effective process in place for medicines reviews. We found that this was done opportunistically which was not in line with the practice repeat prescribing policy which stated that repeat prescriptions would last for an agreed length of time before a medicine review is carried out. Dispensary staff had no role in determining when a patients' medication review was due and it was not clear how a patient would be alerted to a need for a review. The GP told us that they knew their patients well and would request people to attend for review when she signed prescriptions. Since the inspection the principal GP had reviewed the medicines of 1% who had repeat prescriptions. Evidence they provided showed that 96% of patients on four medicines or more had received a review in the last 12 months. Since the inspection the practice had put in place a medication review flowchart to provide guidance to all staff which included locum GPs.
- We checked the system in place for the management of high risk medicines, which included regular monitoring in accordance with national guidance. The practice were unable to demonstrate that the system they had in place was effective to protect the health and safety of patients on these high risk medicines. We found that patients did not have an alert in place to ensure prescribers were aware of the medicines a patient was being given. The lead GP told us they conducted a monthly search to identify the patients who required active monitoring but there was no written protocol or procedure to describe how patients receiving medicines that required regular monitoring would be recalled for this monitoring to take place. A two cycle audit had been completed to identify patients with outstanding

monitoring. Audits carried out showed that the results had dropped from 94% in 2016 to 83 % compliance in 2017. Individual patients who required a follow up had been contacted but we did not see any evidence that this audit had led to a change in practice or an improvement in patient outcomes.After the inspection the practice sent evidence that a high risk drug protocol was now in place to provide guidance to staff.

- The practice did not hold controlled drugs (CDs) (medicines that require extra checks and special storage because of their potential misuse) and patients who would normally have their medicines dispensed at the practice took prescriptions for CDs to a local community pharmacy to be dispensed.

  The service provided weekly medicines packed into blisters for patients who needed this level of support. Dispensers were not aware of certain medicines that should not be packed in this way. We saw that the process for packing medicines into the blisters ensured staff were not disturbed to reduce the risk of errors.

- We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. They had a system in place to ensure fridge temperatures were being checked and reset on a daily basis. However the practice did not complete monthly calibration or have a second thermometer independent of mains power so temperatures can be measured in the event of electricity loss. This would enable the practice to document what temperature the fridge interior rose to in order for a decision to be made on whether there has been a break in the cold chain. Since the inspection we have seen evidence that data loggers have been ordered.

- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. When a PGD was not available the practice nurse was able to administer certain medicines using patient specific directions authorised by the GP.

- We reviewed four personnel files and found that there were inconsistencies and gaps in the recruitment checks undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and appropriate checks through the Disclosure and Barring Service were not available in all files. (These 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).

Monitoring risks to patients

Not all risks to patients were assessed and well managed.

- There was a health and safety policy available. However on the day of the inspection the practice could not find the health and safety risk assessments which looked at areas such as slips, trips and falls, manual handling or lone working. Since the inspection the practice the practice have sent us two health and safety risk assessments dated 12 July 2017. It was documented that staff would receive annual training but on the day of the inspection we did not see any evidence that this had taken place.

- We asked to look at the fire risk assessment and on the day of the inspection the practice were unable to find it. After the inspection the practice carried out their own fire risk assessment. We found that they had not made a suitable and sufficient assessment of the risks to which relevant persons are exposed for the purpose of identifying the general fire precautions needed as set out in the Regulatory Reform (Fire Safety) Order 2005. Risks had been assessed, however no actions had been identified and no action plan had been put in place. For example, staff to be trained on fire safety, how to use the fire alarm warning system and in the use of fire equipment. In one area of the building we found that it did not have appropriate emergency lighting. We have referred the practice to the Lincolnshire Fire and Rescue service. Since the inspection the practice had installed one further emergency light in this area.

- We saw a document dated 13 October 2017 which stated that the GP had instructed staff on what to do in the event of a fire and they had had a fire drill but no information had been documented of what the training entailed or the outcome and any actions from the fire drill. On the day of the inspection we looked at the fire safety policy which did not identify if fire marshals were in place and it did not provide enough guidance to staff. On the day of the inspection we did not see a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. Since the inspection the practice had

provided a further version of the fire policy in which a nominated fire officer, deputy fire officer and fire marshall had been identified. However the policy still does not provide enough guidance for staff, for example, in regard to fire risk assessment, testing of emergency lighting and staff training.

- We looked at the arrangements in place for the management of legionella. We saw that the practice had carried out their own legionella risk assessment on 6 January 2015. It was undertaken by the GP who had not undertaken any relevant training. On the day of the inspection we found that regular water temperature monitoring was carried out by a member of staff but we did not see any evidence that they had the relevant training to undertake this role. Since the inspection the practice had contacted an external provider and were in the process of arranging date for a further risk assessment to be carried out.
- Since the inspection external companies have completed fire safety and management of legionella risk assessments. Action plans have been put in place and we will review the improvements at the next inspection'.
- We found that clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. However the practice could not evidence that all the electrical equipment in the building had been checked. We found pieces of equipment that had last received an electrical check in 2008. We have since been sent a Portable Appliance Testing certificate dated 2 November 2017'.
- On the day of the inspection the practice were unable to show us that they had a five year Electrical Installation Condition Report (EICR) in place. Since the inspection the practice have sent evidence that an EICR report had taken place on 1 October 2016. In the summary of the report it was documented that the installation appeared to be satisfactory with recommendations for improvement. The practice did not provide any evidence that the recommendations had taken place.

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.
- The practice were unable to evidence that all staff had received annual basic life support training however there were emergency medicines available in the treatment room. Since the inspection you have told us that all staff are now up to date with this training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit was available in the dispensary area.
- The surgery held a limited stock of emergency medicines in a secure area of the practice and staff were aware of their location. Others were kept in the doctor's bag. We found that when the doctor took the bag off-site locum staff did not have access to full range of medicines to treat foreseeable emergencies. For example there would be no access to an The doctor undertook to rectify this immediately.
- The practice had a continuity and recovery plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and contractors. However further information to ensure all the relevant risks to the practice were documented and actions to mitigate the risks were in place. Since the inspection the plan had been updated and included an overview of risk and the impact of the risks to the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

On the day of the inspection we found that the practice did not have a formal system in place to keep staff up to day with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff we spoke with told us they were aware of current guidance relevant to their role but could not give us any examples. 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 100% of the total number of points available, with 5.7% exception reporting which was 3.2% below the CCG average and 4.1% below the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

For example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 96.4% which was 2.9% above the CCG average and 5.1% above the national average. Exception reporting was 2.4% which was 2.1% below the CCG average and 3.1% below the national average.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that includes an assessment of asthma was 100% which was 22% above the CCG average and 24.4% above national average. Exception reporting was 0.5% which 2.6% below the CCG average and 7.4% below national average.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 93.2% which was 6.7% above the CCG average and 7.3% above the national average. Exception reporting was 3% which was 0.1% below the CCG average and 0.9% below national average.
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional was 95.5% which was 1.8% above the CCG average and 5.9% above the national average. Exception reporting was 15.4% which was 7.6% above the CCG average and 3.9% above the national average.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 100% which was 12.4% above the CCG average and 16.2% above the national average. Exception reporting was 1.2% which was 2.6% below the CCG average and 5.6% below national average.

There was some evidence of quality improvement including clinical audit.

- We looked at seven audits which had been carried out within the last two years. Four were full cycle, two related to medicines management. We found that the audits would benefit from more structure and detailed analysis together with action plans to monitor implementation of any recommendations. On the day of the inspection we did not see a programme of continuous audits to monitor quality and to make improvements.
- Between April and November 2016 the practice had carried out a Dispensary Services Quality Scheme (DSQS) audit for patients who had reviewed a DRUM review. Data reviewed showed that 96% of patients found the dispensary to be excellent or good overall. 99% were happy with the opening hours of the dispensary.

Effective staffing

At this inspection we found that the system in place to identify and monitor the training needs of all staff was not effective.

- The practice told us and we saw that they had an induction programme for all newly appointed staff. Only one member of staff was a long term employee. Three members of staff had been in post for less than three months and one member of staff had been in post for two years.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice could not demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions such as diabetes, asthma and COPD and no evidence of updates for dispensers once they had obtained their NVQ2 qualification. Since the inspection we have reviewed evidence that the practice nurse had had supervision with the lead GP in which long term conditions were discussed and a plan was in place to ensure relevant training was provided.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. At the inspection staff who administered vaccines could demonstrate the training they had received and how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.
- We found that the system in place in relation to the identification and monitoring of the training needs of all staff were not effective. For example, safeguarding, fire safety, basic life support, infection control and information governance. Staff had recently been given access to and some had made use of e-learning training modules.
- We saw from records we reviewed that staff received a yearly appraisal.
- On the day of the inspection we were told and we saw that the GP locum induction pack was in the process of being updated

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 that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. However the practice did not have a process to monitor if the patients had received and attended an appointment.
- We found that the practice did not have a clear system for checking and acting on abnormal pathology results. At this inspection we found a backlog of 40 results which dated back to 10 October 2017. We were not assured that action had been taken and information regarding the action documented. Since the inspection the principal GP had informed us that all pathology results are dealt with within 48 hours with urgent results reviewed in 24 hours. The 40 results had been dealt with but had been kept in the inbox to ensure further tests were actioned by the practice nurse.We did not see any evidence of a protocol to guide the nurse on potential actions to take.
- Staff worked together and 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. We were told by the GP that all discharge letters were reviewed and actioned on the day they were received.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice worked with external organisations such as St Barnabas Hospice and the Macmillan nurse service.

Consent to care and treatment

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

- Clinical staff we spoke with 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.
- The practice had 14 patients with Deprivation of Liberty Safeguards DoLs) in place. DoLs relate to people who lack mental capacity who need to be placed and detained in care homes or hospitals for their treatment or care and to protect them from harm. None of them had an icon in place on their electronic patient record.
- There was a practice policy for consent and we were told that verbal consent was documented on the patient electronic record.

Requires improvement

Are services effective?

(for example, treatment is effective)

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, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and those who health care related issues that impacted on their well-being.
- The practice worked closely with the Pennygate Foundation, a charitable trust which ran from premises next door. The foundation provided a wealth of services for all age groups and for those whose were vulnerable who suffered from mental health needs. They also provided advice, advocacy and signposted patients to other organisations.

The practice's uptake for the cervical screening programme was 76%, which was below the CCG average of 84% and the national average of 81% but we did not see any evidence of a plan to improve the uptake.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above to CCG/national averages. For example, rates for the vaccines given to under two year olds and five year olds was 100%.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- 52% of patients had been screened for bowel cancer which was below the CCG average of 62% and national average of 58%.
- 67% of patients had been screened for breast cancer which was below the CCG average of 79% and national average of 72%.

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. However on the day of the inspection we found that the area currently used could breach confidentiality as it was adjacent to the reception where receptionists answered the telephone and the computer screen was visible. We spoke with the management team who told us they would review this and make arrangements to ensure confidentiality at all times.

34 Care Quality Commission comment cards we received were all extremely positive about the standard of care received. Patients who completed these cards said the service provided was excellent. Staff were professional, friendly, compassionate and respectful. Friendly. They took the time to listen and were very understanding. They also said that staff responded compassionately when they needed help and provided support when required.

We spoke with two members of the Pennygate Patient Link (PPL). They told us that their main purpose was to raise funds to buy equipment for the practice and the community. They felt they were very well supported and listened to by the practice. They also said that staff responded compassionately when they needed help, worked well as a team and provided support when required.

Results from the July 2017 national GP patient survey showed the practice was below the CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 91%.
- 70% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.
- 85% 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%.
- 69% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 86%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 74% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The practice had reviewed the July 2017 results and had put an action plan in place to address areas such as ability to get through by telephone and the availability of telephone triage appointments. However the review had not considered conducting a patient survey to address all the areas that were below CCG and national average.

The views of external stakeholders were positive. For example, staff from three local care homes where some of the practice's patients lived praised the care provided by the practice. Visits by the GP took place at a convenient time, there was no rush and time was taken to listen to both patients and staff.

Care planning and involvement in decisions about care and treatment

Results from the July 2017 national GP patient survey showed patients did not feel involved in planning and making decisions about their care and treatment. Results were below local and national averages. For example:

- 75% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.

Requires improvement

Are services caring?

- 68% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

We found that comments cards we reviewed told us that patients felt listened to and supported by staff.

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

- 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 informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in the waiting room with some in written in different languages for patients who did not have English as a first language.
- The NHS e-Referral Service was used with patients as appropriate. (The NHS e-Referral Service 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 which included the Pennygate Foundation.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 187 patients as carers (5.4% of the practice list). We did not see any written information in the waiting room available to direct carers to the various avenues of support available to them with the exception of the Pennygate Foundation. However there was a link to Carers direct on the practice website.

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. For example,

- We found good access to appointments for both GPs and the nursing team. We reviewed access to appointments and found good availability for on the day and next day appointments. Appointments were also bookable up to six months in advance
- The practice offered extended hours on a Tuesday Evening from 6.30pm to 8.30pm. We were told that the practice rarely had patients who did not attend (DNA) for their appointment. We found that the practice had not had any patients DNA in the last month.
- There was a large waiting area to accommodate patients with restricted mobility or parents with children in prams.
- 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.
- Patients were able to receive travel vaccines available on the NHS. Patients were referred to other clinics for vaccines available privately.
- There were accessible facilities and interpretation services were available but the practice did not have a hearing loop in place.
- All patient facilities were on the ground floor level.
- 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.

Access to the service

Pennygate Health Centre were open from 8am to 6.30pm Monday to Friday.GP Appointments were from 8.45am to 11am and 3.30pm to 5.30pm Monday to Friday.

In addition to pre-bookable appointments that could be booked up to six months in advance.

The practice had extended hours on a Tuesday evening from 6pm to 8.30pm.

Results from the July 2017 national GP patient survey showed that patients' satisfaction with how they could access care and treatment were below local and national averages in most areas.

- 61% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 76%.
- 60% of patients said they could get through easily to the practice by phone compared to the CCG average of 74% and the national average of 71%.
- 65% of patients said that the last time they wanted to speak to a GP they were able to get an appointment compared with the CCG average of 63% and the national average of 56%.
- 70% of patients said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 65% of patients described their experience of making an appointment as good compared with the CCG average of 77% and the national average of 73%.
- 53% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 63% and the national average of 58%.

We spoke with staff from three local care homes who told us they were very satisfied with the overall service provided by Pennygate Health Centre. They told us that they were able to get a home visit whenever they needed one.

Comments cards we reviewed aligned with these views and most patients told us they could get appointments when they needed them.

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. We did not see any evidence that the reception staff had received any specific training in reception triage to carry out this role. Furthermore there was no clear triage policy to ensure patient safety.

Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system For example, in the practice leaflet.
- 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 under practice policies.
- Prior to our inspection we had received concerns from members of the public in regard to the training of staff and the process for the signing of prescriptions. We looked at both concerns and found that staff required training updates and the process for the recording training and relevant records were not effective. The process for the use of prescriptions was effective on the day of the inspection.
- The practice had received seven complaints over the past 12 months. From records we looked at we found that the complaints they had dealt with had been responded to in a timely and appropriate way. However the response letters did not contain details of who they could go to if they were not satisfied with the response. We spoke with the GP lead who told us they would amend this for future complaint responses.
- Prior to our inspection we had asked to see a summary of all complaints received in the last 12 months. We were sent a Data submission summary which identified four complaints up to 6 June 2017 but this did not include an analysis of trends and action taken to as a result to improve the quality of care.
- From the complaints we reviewed we saw that lessons had been learnt and actions put in place, for example, one complaint response stated that a significant event would be completed and discussed at a meeting. We saw a significant event which clearly detailed the event and actions and learning that had taken place. However from meeting minutes we reviewed we did not see any evidence that complaints had been shared with staff.

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 told us that they provide a consistently high standard of medical care. They were committed to the needs of their service users and would involve them in decision making about their treatment and care and encourage them to participate fully. This aligned with the views of the patients who completed the Care Quality Commission comments cards prior to the inspection.

However on the day of the inspection 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.

Governance arrangements

We found that overall leadership was not effective. We found a lack of accountable leadership and governance relating to the overall management of the service. Systems and processes in place were not established or operated effectively to ensure compliance with good governance. The practice was therefore unable to demonstrate strong leadership in respect of safety.

The practice had 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).

We found:-

- 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, safeguarding, medicine reviews, monitoring of patients on high risk medicines, monitoring of the cold chain, recruitment and retention of staff, and NICE guidance.
- Risks to patients were assessed but the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- The system in place for monitoring adults and children on the at risk register and identifying looked after children was not effective as we could not evidence that there was a consistent process in place to identify those at risk.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example, checking and acting on abnormal blood results and monitoring of patients who had had referrals to secondary care.
- We saw limited clinical improvement work had taken place in order to monitor quality and make some improvements.
- The system in place to monitor the training of the GPs and staff within the practice was not effective. For example, not all clinical staff had received appropriate training in safeguarding to ensure they were up to date with current procedures.
- The practice could not demonstrate that they proactively sought feedback from staff and patients, which it acted on.
- On the day of the inspection the information technology system in place was not fit for purpose as staff were unable to retrieve documents from an external drive. This was referred to the South Lincolnshire Clinical Commissioning Group as a concern.

Leadership and culture

The practice was led by a principal GP with the support of a practice nurse and administration staff. They told us they prioritised safe, high quality and compassionate care. However we found a lack of focus on the clinical leadership and governance systems required which resulted in significant issues that threatened the delivery of safe and effective care which had not been identified or adequately managed.

Staff told us, local care home staff and comments cards we reviewed told us the principal GP and staff were approachable and always took the time to listen to patients and members of staff.

The provider was aware of and had some systems in place to ensure compliance with the requirements of the duty of candour. (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).

The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology

Are services well-led?

Inadequate

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

There was structure in place but we found that the practice did not have effective leadership in place.

- Staff we spoke with told us they felt supported.
- We saw and we were told that there had been a 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.

However, we found,

- Whilst we saw evidence of some meetings taking place, these did not include all areas of practice governance and allow opportunities for learning.
- We were told that the practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns. However we were only given one set of palliative care meeting minutes for 8 March 2017 and these were limited.
- Practice meetings took place but 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.
- Staff said they felt respected, valued and supported by the principal GP and colleagues who worked at the practice.

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.

- The practice had a very active patient participation group which was known as the Pennygate Patient Link (PPL). It ran a charity which was registered in its own right and was staffed by volunteers. The main purpose was to raise funds to buy equipment for practice and patients in the community. We spoke with two member of the PPL who told us that they had submitted proposals for improvements to the principal GP. For example, self-check in monitor and a TV screen so that patients can see their name when they are called by the GP. The TV screen will also be used for patient information.
- We asked the PPL if they had undertaken any patient surveys and were they aware of the current national patient survey data for the practice. The PPL told us they were not aware that the practice had not met 22 out of the 23 outcomes. They went onto to say they would review the survey results and discuss with the principal GP about future surveys for the practice.
- The practice had reviewed the July 2017 national patient survey results and had put an action plan in place to address areas such as ability to get through by telephone and the availability of telephone triage appointments. However the review had not considered conducting a patient survey to address all the areas of concerns identified by the patients registered at the practice that were below CCG and national average.
- We saw that the practice encouraged patients to complete the NHS Family and Friends (FFT). However we did not see any evidence that this had been collated and discussed or any actions put in place for improvements. Since the inspection the practice have sent us the analysis from the family and friends testing for April 2016 to November 2017. The data demonstrated that :-From April 2016 to March 2017, 684 patients completed the FFT cards with 62% extremely likely and 36% likely to recommend the practice to others. From April 2017 to November 2017, 445 patients had completed the FFT cards and 70% were extremely likely and 36% likely to recommend the practice to others.

Continuous improvement

On the day of the inspection we did not see any evidence of continuous learning and improvement within the practice.

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.**