

Sidley Medical Practice

Quality Report

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous rated inspection 16 June 2017 – Requires Improvement.)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Sidley Medical Practice on 9 January 2018 to follow up on breaches of regulations. The practice was inspected initially on 23 August 2016 and found to be in breach of the regulations. At a follow up inspection on 16 June 2017 the practice was still found to be in breach of the regulations and a warning notice was issued in line with our enforcement policy. On 21 August 2017 the practice was again inspected to ensure that the terms of the warning notice had been complied with and we found that sufficient improvement had been made to comply with the warning notice. This inspection was not rated.

At this inspection we found:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. When incidents did happen, the practice learned from them and improved their processes.
- The practice had systems in place to review the effectiveness and appropriateness of the care it provided. Care and treatment was delivered according to evidence-based guidelines.
- The practice had reliable systems for the management of medicines with the exception of recording the temperatures of vaccine fridges and the checking of expiry dates of emergency medicines.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Summary of findings

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was reasonable access to appointments which could be booked in advance or were available on the day.
- The practice encouraged, and acted on, feedback from staff and patients, including via its complaints system. The provider was aware of and complied with the requirements of the Duty of Candour.
- The practice had reviewed its leadership and governance structure and staff felt supported by management.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Ensure that maximum, minimum and actual fridge temperatures are recorded with an explanation if found to be outside the agreed parameters.

Ensure medicines in the emergency kit are within date and available for use.

The areas where the provider **should** make improvements are:

Consider recording both online and face to face training in a single place.

Consider reviewing recruitment interview questions so that explanations of gaps in employment history are always asked about and recorded.

Consider what action to take to enable all patients to attain access to a named accountable GP and to the full range of services including online services.

Monitor and seek to improve any areas of chronic disease management, the management of mental health conditions and childhood immunisation rates that fall below the local and national average.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General 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	Good	
People with long term conditions	Good	
Families, children and young people	Good	
Working age people (including those recently retired and students)	Good	
People whose circumstances may make them vulnerable	Good	
People experiencing poor mental health (including people with dementia)	Good	

Sidley Medical Practice

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 adviser and a practice manager adviser.

Background to Sidney Medical Practice

Sidley Medical Practice provides general medical services to approximately 15,500 patients and operates from two sites in Bexhill-on-Sea. These are known as Sidney Surgery, a purpose built premises in a residential area with a link to an adjacent pharmacy, and Albert Road Surgery that is located in the town centre and based in a converted residential property.

Patients can access services provided from either location:

Sidley Surgery, 44 Turkey Road, Bexhill-on-Sea, East Sussex, TN39 5HE.

Or

Albert Road Surgery, 24 Albert Road, Bexhill-on-Sea, East Sussex, TN40 1DG.

There are six GP partners (three female and three male) and three salaried GPs (two female, one male). The practice is accredited to provide both teaching and training. It supports medical students and provides training opportunities for qualified doctors seeking to become GPs. At the time of the inspection there were two postgraduate doctors training at the practice. The practice had lost several GPs over the preceding two years and were currently trying to recruit.

In addition there are nine members of the nursing team; six practice nurses (one male, five female) one of whom is training to be an advanced nurse practitioner, an associate practitioner, two health care assistants (all female) and a clinical pharmacist. There is a senior management team overseeing day to day operations. This includes a senior GP partner, a self-employed consultant acting as an interim practice manager, a deputy practice manager and four managers. There are 24 members of reception/administration staff supporting the practice.

Both practices are open Monday to Friday between 8am and 6:30pm with a lunchtime closure from 1pm to 2pm; during this time patients can call the normal surgery phone number and a duty doctor is available.

Appointments can be booked over the telephone, online or in person at the surgery. Patients are provided information on how to access an out of hours service by calling the surgery or viewing the practice website.

Data available to the Care Quality Commission (CQC) shows the practice is located in an area that is considered to be slightly more deprived than the national average. People living in more deprived areas tend to have greater need for health services. Statistically, this practice area has a higher number of people with a long-standing health condition when compared to the national average and the number of people suffering income deprivation is higher than the national average.

This practice serves a higher than average number of patients who are aged over 65 years when compared to the national average. The number of patients aged from birth to 18 years is slightly lower than the national average.

The practice offers a number of services for its patients including; family planning, minor surgery, hypertension clinics, drug and alcohol misuse services, smoking cessation, and travel vaccines.

Detailed findings

The practice has a General Medical Services (GMS) contract with NHS England. (GMS is one of the three contracting routes that have been available to enable commissioning

of primary medical services). The practice is part of the NHS Hastings and Rother Clinical Commissioning Group. The practice list is currently closed to new patients. See the practice website for further information.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as requires improvement for providing safe services.

The practice was rated as requires improvement for providing safe services because:

At the last rated inspection in June 2017 it was found that there were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- The provider had failed to identify the risks associated with insufficient processes and records for identifying, acting on, reviewing and monitoring patient and medicine safety alerts issued from the Medicine and Healthcare products Regulatory Agency.
- The infection control audit action plan was incomplete and records of cleaning of medical equipment were not kept.
- Not all staff were aware of significant event processes and reporting.
- Recruitment procedures had improved, although references for one member of clinical staff had not been requested prior to employment.

At this inspection each of these issues had been resolved.

We did find however that although the maximum, minimum and actual temperatures of the fridges containing vaccines and other medicines were recorded, they were on occasions found to be above the upper end of the accepted range without a clear explanation of the actions taken by the practice in response being recorded.

We also found that the contents and dates of expiry of the medicines in the emergency kit were checked on a monthly basis and were last checked in December 2017 and found to be in date. However three single use packs of one of the medicines had an expiry date of the end of December 2017 and had not been removed when we looked on 9 January 2018.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. We saw minutes of meetings where new safeguarding guidance and advice was discussed and actioned.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration and professional indemnity where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- We reviewed three staff files to assess that background checks had been carried out prior to employment. All the files contained all of the expected background checks including two references from previous employers. All three files contained interview notes although we did note that in one file the applicant hadn't been asked about gaps in their employment history.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. Only clinical staff or managers acted as chaperones.
- There was an effective system to manage infection prevention and control. Both sites had a recently appointed infection control lead as the previous lead had left the practice. Both had been booked on to an infection control leaders' course in the near future.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Are services safe?

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role and a locum pack was available for all GP locums. The practice only used locums from a pool of five trusted locums.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis which we saw had been discussed at a clinical meeting.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had mostly reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use. However although the maximum, minimum and actual temperatures of fridges were recorded daily, on some occasions temperatures were found to have been just above the range and on all but one occasion an explanation was not recorded. The practice advised us that this would have been because the doors had been opened to take vaccines out or check stock, but would

not have affected the viability of the medicines.

Following the inspection, the practice told us, they have since taken advice from the manufacturers and the clinical commissioning group pharmacy team and the both had confirmed that they need take no further action. They were putting revised systems in place to resolve the issues with the temperature recording.

- We also found that although the contents and dates of expiry of the medicines in the emergency kit were checked on a monthly basis and were checked in December 2017 and found to be in date, three single use packs of one of the medicines had an expiry date of the end of December 2017 and had not been removed when we looked on 9 January 2018. The practice removed the medicines when this was pointed out. There were packs of the same medicines remaining in the kit that had not reached their expiry date.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. Among other roles, the clinical pharmacist reviewed medicines on discharge from hospital and we saw a significant event where a patient had been discharged from hospital on an inappropriate drug, that was picked up by the pharmacist and the issue resolved.

Track record on safety

The practice had a good safety record.

- There were risk assessments in relation to safety issues. The practice had employed the services of a specialist company to assist with risk assessment. The member of staff leading on risk assessments received on-site training from the company, carrying out risk assessments in conjunction with the trainer and we saw evidence of action taken in response to the assessments. The practice had carried out risk

Are services safe?

assessments including infection control, fire safety and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took

action to improve safety in the practice. The practice had recorded, discussed, acted on, reviewed and shared learning on 41 significant events in the previous year. We saw that they were thoroughly investigated as a standing agenda item alongside complaints at clinical meetings. For example a patient had been on a medicine for some years and had been suffering from persistent headaches. When she saw a new GP they realised that there were contraindications to the use of the medicine in that patient and that the headaches may be a side effect. The practice raised the issue as a significant event, analysed and discussed the issue, apologised to the patient and ran an audit of patients on similar medicines.

- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. New safety alerts and changes in guidance were discussed at regular clinical meetings.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice good for providing effective services overall and across all population groups

At the previous rated inspection in June 2017 the practice was rated as requires improvement for providing effective services. This was because there were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular there was minimal evidence of quality improvement and monitoring through clinical audit. Additionally Governance arrangements had not identified gaps in appropriate staff training requirements and had not ensured appraisals were carried out for all staff within a specified timescale (where eligible). At this inspection we saw that all of these issues had been resolved by the practice.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. We saw that since the last inspection in June 2017, there was a standing agenda item at clinical meetings that included NICE (National Institute of Health and Care Excellence) guidelines, prescribing updates and audits and that any issues or guidelines were discussed thoroughly and where necessary action taken.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

This population group was rated good for providing effective care.

- Older patients who were identified from health analytics as being frail or vulnerable were referred to the Proactive Care Team. Social and medical issues were discussed in a monthly multidisciplinary meeting at the practice to assess their needs.

- At risk patients over 75 years were reviewed and those patients were given a telephone number that allowed them fast access to the surgery. Care plans were put in place and reviewed regularly.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- Arrangements were in place to provide flu, shingles and pneumococcal immunisations.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

This population group was rated good for providing effective care.

- Patients with long term conditions were closely monitored to try and prevent hospital admissions. If a patient was admitted they were followed up on their return with a phone call or visited. They were also referred to proactive integrated care management.
- There were rapid access appointments for those with urgent needs and the practice offered home visits. NHS health checks aimed to identify patients with chronic disease early.
- The practice held disease registers for a wide range of chronic conditions. Patients with long-term conditions had a structured review at least annually to check their health and medicines needs were being met. For patients with the most complex needs, the GPs and nurses worked with other health and care professionals to deliver a coordinated package of care.
- Patients were encouraged to take responsibility for their illness and support and education was provided. Patients with Diabetes were able see a Diabetes Specialist Nurse and joint consultations were carried out for any complex patients.
- They encouraged use of exercise and weight management for obesity and supported patients who had long term conditions to make lifestyle changes.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- There was one area where QOF results for long term conditions were calculated by CQC data analysts to be a

Are services effective?

(for example, treatment is effective)

negative variation from the national average. This was: The percentage of patients with hypertension whom the last blood pressure was 150/90 mmHg or less (practice 74%, CCG average 83%, national average 83%). The practice had taken steps to improve these figures for 2017/2018.

Families, children and young people:

This population group was rated good for providing effective care.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above in three out of four of the indicators. In the fourth the percentage of children aged 2 with pneumococcal conjugate booster vaccine was 69%. All children who failed to make appointments or failed appointments for immunisations were contacted and followed up.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- Clinicians promoted sexual health screening at the local clinic.

Working age people (including those recently retired and students):

This population group was rated good for providing effective care.

- The practice's uptake for cervical screening was 72%, which was lower than the 80% coverage target for the national screening programme. However the local clinical commissioning group average was 75% and the national average 72%.
- The practice identified patients who had not come in for cervical smears and had a smear recall system in place.
- The practice opportunistically offered eligible patients the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated good for providing effective care.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice were supported in this by the hospice at home team.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability. Homeless people, asylum travellers and carers were all highlighted and had their records tagged. Military veterans were also tagged in the notes.
- Patients with learning disabilities could have reviews in their own home if appropriate.

People experiencing poor mental health (including people with dementia):

This population group was rated good for providing effective care.

- 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable to the national average of 84% and CCG average of 84%.
- 70% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is worse than the national average of 90% and CCG average of 88%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 81%, CCG 86%, national 91%).
- The practice provided weekly scripts for patients in danger of over using medicines and worked closely with the local pharmacist.
- Same day appointments and telephone triage was employed for patients with acute mental health concerns.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Since the previous inspection in June the practice had put in place an audit dashboard which included policies and when the audits needed to be completed. There were

Are services effective?

(for example, treatment is effective)

audits that had been carried out and planned audits. Audits were also a standing agenda item at clinical meetings. For example following a significant event it was discovered that the system for ensuring that regular tests for hormone levels in some conditions could be improved. As a result of the audit, alerts were added to notes and quarterly searches were run to ensure that the tests were carried out on affected patients at the correct intervals.

The most recent published Quality Outcome Framework (QOF) results (1 April 2016 to 31 March 2017) were 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall exception reporting rate was 8% compared with a CCG average of 10% and a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

There were two areas where QOF results were calculated by CQC data analysts to be a negative variation from the national average. These were:

- The percentage of patients with hypertension whom the last blood pressure was 150/90 mmHg or less (practice 74%, CCG average 83%, national average 83%).
- The percentage of patients with mental health issues who had a comprehensive care plan documented in the record was 70% (CCG average 88%, national average 90%).

The practice were aware of these specific issues and had now allocated a GP to lead in each QOF area. There was a new multi-disciplinary approach to chronic disease management and the leads worked with a newly formed Patient Liaison Team who were a dedicated team formed to co-ordinate the management of long term conditions. Their role was to manage the recall of patients, to ensure that none were missed and also that they did not have to make unnecessary appointments. They also organised relevant investigations and tests.

- The practice used information about care and treatment to make improvements. For instance

following a practice medicines management initiative the practice changed its use of specific antibiotics for urinary tract infections in line with guidelines. This was followed up by an audit.

- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives. They were involved in a local CCG pilot in care navigation (directing patients to the most suitable person to address their issues). They also engaged with the CCG pharmacy team to improve medicines management.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained, although records of online training and face to face training were kept separately. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

Are services effective?

(for example, treatment is effective)

- 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. They were supported by the local hospice at home team.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Eighteen of the of the 26 patient Care Quality Commission comment cards we received were positive about the service experienced. Four of the cards were mixed with concerns about patients not having their own named GP and accessing bookable appointments. Four cards were negative also mainly about the appointments system and one about repeat prescriptions. The results of the NHS Friends and Family Test run over the six months from July to December since the last rated inspection showed that 85% of patients (1326 out of a total of 1564) were extremely likely or likely to recommend the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 226 surveys were sent out and 113 were returned. This represented about 0.7% of the practice population. The practice was above average for some of its satisfaction scores on consultations with GPs and nurses. For example:

- 97% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 96% of patients who responded said the GP gave them enough time compared with the clinical commissioning group (CCG) average of 87% and the national average of 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw compared with the clinical commissioning group (CCG) average of 95% and the national average of 95%.

- 93% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 93% of patients who responded said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 95% of patients who responded said the nurse gave them enough time compared with the clinical commissioning group (CCG) average of 94% and the national average of 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw compared with the clinical commissioning group (CCG) average of 97% and the national average of 97%.
- 94% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 93% of patients who responded said they found the receptionists at the practice helpful compared with the clinical commissioning group (CCG) average of 88% and the national average of 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Telephone translation services were available for patients who did not have English as a first language as well as interpreters for the hearing impaired. We saw notices in the reception areas, informing patients this service was available.
- There was a television screen in the waiting room with messages in large print and information could be printed in large print by the reception staff.
- A hearing loop was available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Are services caring?

- The practice had a small room in reception that could be used to discuss confidential issues. It had an access door from the back of reception and one from the waiting room with a counter separating the two parts of the room.

The practice proactively identified patients who were carers. Carers were identified at registration with the practice, there were also posters in the waiting room and pages on the website dedicated to carers and offering to register them as such. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 382 patients as carers (2.5% of the practice list).

- A member of staff had recently been appointed carers' champion and had undertaken training with a local carers' support service. Their role was to identify and contact carers to help ensure that the various services supporting carers were coordinated and effective. They had been given protected time to carry out this role.
- We were told that if families had experienced bereavement, their usual GP contacted them and offered them an appointment and/or gave them advice on how to find a support service if appropriate.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were above local and national averages:

- 92% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 86% and the national average of 86%.
- 92% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 81% and the national average of 82%.
- 92% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 90% and the national average of 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the clinical commissioning group (CCG) average of 85% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good across all population groups for being responsive to people's needs.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example the duty GP each day offered book on the day appointments up until 7.30pm each weekday and online services such as repeat prescription requests and advanced booking of appointments. Prescriptions could be sent via the electronic prescription service (EPS) to a pharmacy of the patient's choice.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. The premises and facilities were easily accessible to those with mobility issues and they provided a hearing loop, translation service, baby changing facilities and breast feeding space.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice told us they had lost nine GPs over the preceding two years and were running, and wished to continue to run, personal lists. This meant that about 6000 patients did not have a named accountable GP. The practice did have in place a system that meant that those patients had all investigations and other work looked at each day by one of the partners, these were then triaged, allocated to a GP and dealt with within the day. However it did mean that because of the way the way the IT system worked, these patients couldn't access the online services (repeat prescriptions, electronic prescription service and on-line booking.) The practice had been working on a plan to allocate patients to an accountable GP in tranches of groups related to vulnerability and had recently allocated all

patients over 75 an accountable GP. They have told us since the inspection that they will be allocating every patient a named accountable GP by the end of January 2018.

Older people:

This population group was rated good for being responsive.

- All patients over 75 had a named accountable GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with urgent needs.
- Housebound and frail patients are able to order prescriptions over the telephone.
- The practice had noticed an increasing number of patients presenting with low mood and loneliness in old age and directed them to appropriate support organisations.

People with long-term conditions:

This population group was rated good for being responsive.

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Consultation times and lengths were flexible to meet each patient's specific needs.
- The practice held regular meetings which included the local community nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

This population group was rated good for being responsive.

- Children were given priority for emergency same day appointments and telephone consultations.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances and those that did not attend appointments. The practice worked closely with the health visitor. There was a safeguarding administrator who linked vulnerable patients with family members. Records we looked at confirmed this.

Are services responsive to people's needs?

(for example, to feedback?)

- The practice offered six weekly post-natal checks and worked closely with mid-wives.

Working age people (including those recently retired and students):

This population group was rated good for being responsive.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone consultations were available including between 6.30pm and 7pm which supported patients who were unable to attend the practice during normal working hours.
- The duty doctor surgery commenced at 5.30pm and had urgent appointments until 7.30pm each weekday evening.
- If they had a named accountable GP, patients were able to book appointments and order repeat prescriptions online. The practice used an electronic prescription service (EPS) allowing patients to collect medication from any pharmacy of their choice.
- They encouraged telephone consultations for some medication reviews, results and advice.

People whose circumstances make them vulnerable:

This population group was rated good for being responsive.

- The practice highlighted patients living in vulnerable circumstances including homeless people, asylum seekers and those with a learning disability. They would be offered longer appointments if appropriate.
- Patients with learning disabilities had annual reviews and were encouraged to participate in health promotion activities.
- There was regular liaison with midwives, counsellors, district nurses and health visitors.

People experiencing poor mental health (including people with dementia):

This population group was rated good for being responsive.

- Many patients with dementia had carers and were directed by the carers' champion to benefit and support services, groups and day centres.
- Patients with poor mental health had care plans in place and where appropriate were referred to proactive care.

- The practice worked alongside the community mental health services, home treatment team and counselling services in caring for patients with mental illness and carried out regular health checks. Emergency contact details were provided in case of a crisis. There was also often an overlap with alcohol and drug use and they regularly referred to the community treatment team to help with this.
- If an appointment was missed, the patient was called to rearrange or a home visit carried out if necessary. The normal 'did not attend' policy did not apply.
- The practice worked closely with the dementia community nurses.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients were reminded by phone 24 hours before specialist clinic appointments and the practice offered a text reminder service.
- Access to bookings was in person, by telephone, online and via an automated phone booking facility.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Vulnerable patients could book longer appointments if required.
- Children would always be offered an urgent appointment on the day if required.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. 226 surveys were sent out and 113 were returned. This represented about 0.7% of the practice population.

- 82% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 67% of patients who responded said they could get through easily to the practice by phone compared with the clinical commissioning group (CCG) average of 73% and the national average of 71%.
- 84% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the clinical commissioning group (CCG) average of 85% and the national average of 84%.
- 77% of patients who responded said their last appointment was convenient compared with the clinical commissioning group (CCG) average of 83% and the national average of 81%.
- 72% of patients who responded described their experience of making an appointment as good compared with the clinical commissioning group (CCG) average of 76% and the national average of 73%.
- 76% of patients who responded said they don't normally have to wait too long to be seen compared with the clinical commissioning group (CCG) average of 65% and the national average of 64%.
- Information about how to make a complaint or raise concerns was readily available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaints policy and procedures were in line with recognised guidance. Seventy six complaints were received in the last year but these were both verbal (52) and written (24 including two about a third party). We reviewed the complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. The complaints had been divided in to four categories about GPs, nurses, administration and third parties. The Quality Assurance lead looked at complaints for trends on a regular basis and the practice looked at them annually. It acted as a result to improve the quality of care. For example a patient complained that they had a long wait at a clinic and eventually left. The practice investigated and found that the patient had checked in at the wrong surgery, but had been checked as attending the correct surgery. The practice apologised and explained what had happened, the patient was happy with an apology and rebooked. The practice discussed the issue with the reception/administration team to avoid similar issues in the future.
- Complaints were a standing agenda item for monthly clinical meetings.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Are services well-led?

Good 

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

Our findings

We rated the practice, and all of the population groups, as good for providing a well-led service.

At the last rated inspection in June 2017 the practice were rated inadequate in well-led. This was because governance arrangements had not identified a lack of response to the breaches of regulation identified in the previous inspection report findings. The practice failed to demonstrate that there was sufficient leadership capability and capacity to ensure governance systems were operated effectively. Specifically the practice had:

- Not ensured all staff understood the process for reporting, recording and acting on significant events.
- The clinical meeting timetable had not been flexible in order to maintain timely discussion of significant event analysis and sharing of learning.
- Not established formal pathways and processes to ensure patient safety and medicine alerts were received, reviewed, actioned and recorded.
- Undertaken an infection control audit in March 2017 but had not identified interventions or timescales for completion of actions. Completed actions had not been documented, including records of cleaning of medical equipment.
- Not identified gaps in recruitment files.
- Not ensured there were systems and processes in place to assess, monitor and improve the quality and safety of services through an on-going audit programme in a range of clinical areas.
- Failed to identify not all staff had received appropriate training relevant to their roles and responsibilities.
- Commenced a programme of appraisals but had only achieved 50% of all staff either receiving an appraisal or being offered pre-appraisal paperwork.
- Failed to ensure staff were aware of the practice vision and business plan and their responsibilities to it. Not all staff felt involved in discussions about how to run and develop the practice.

At this inspection we found that these issues had been resolved.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Significant changes had taken place in the management systems and structures in the previous few months since the last rated inspection and these were evolving and becoming embedded. Staff that we spoke to said that there had been a significant improvement in communication and they felt involved in the running of the practice.

Vision and strategy

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

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. The mission statement was on the screen in the waiting room and on the home page of the website. Staff that we spoke to were aware of it and its contents.
- The practice developed its vision, values and strategy jointly with staff and patients.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice were cultivating a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted if staff exhibited behaviour and performance inconsistent with the vision and values of the practice.

Are services well-led?

Good 

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

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. All staff had had further training in the reporting of significant events and were informed of outcomes and actions.
- There were processes for providing all staff with the development they need. This included appraisal and training conversations. All staff received regular annual appraisals in the last year and appropriate training relevant to their roles and responsibilities.
- Staff were supported to meet the requirements of professional revalidation where necessary. We saw examples of staff who had been encouraged to develop and progress their careers.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was an emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams. All staff that we spoke felt that the management including the GPs were open and accessible. Staff talked of the significant improvement in relationships and communication throughout the practice in the last few months. The practice had held a team building event in the summer and were planning to hold them on a regular basis.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. All staff had received appropriate safeguarding training. New infection control leads had been appointed and all outstanding actions from the previous audit completed.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. However although vaccine fridges had maximum, minimum and actual temperature readings recorded, some temperatures were found to be outside the normal range with no explanation recorded. Also although emergency medicines were checked monthly, we found three single use packs of one of the medicines that had an expiry date of the end of December 2017 and had not been removed when we looked on 9 January 2018.

- The practice had processes to manage current and future performance. Practice leaders had oversight of a comprehensive system for monitoring, discussing and actioning MHRA alerts, incidents, and complaints.
- A new system of clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Clinical meetings included a standing agenda item on clinical standards encompassing NICE guidelines, prescribing updates and audits.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Are services well-led?

Good 

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

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. There were a variety of regular meetings held including daily informal coffee meetings between GPs, nurses and management, monthly multi-disciplinary meetings, regular clinical meetings and partners' meetings which included the practice management. Nurses held regular meetings as did the various working groups (such as the prescriptions team). There were whole practice meetings approximately every three months.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. Patients views were recorded via complaints, the friends and family test, the national survey, the patient participation group (PPG) and requested via posters and in the newsletter. Staff said that their views were asked for and considered and that they felt comfortable raising issues.
- There was an active patient participation group who were encouraged to discuss concerns, comment on surveys and new appointments, such as that of a

paramedic practitioner, with the practice. They helped produce a six monthly news and advice newsletter for patients which asks patients for concerns and suggestions for improvements.

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The practice were a training practice and trained qualified doctors who as part of their general training needed some experience of working in general practice as well as qualified doctors who were specifically training to be GPs.
- Staff knew about improvement methods and had the skills to use them. For example one member of staff had started as a phlebotomist, carried out the required training to become a health care assistant and then trained to the enhanced role of associate practitioner. This allowed them to carry out dressings and wound care in addition to other roles. One of the practice nurses was training to become an advanced nurse practitioner whilst working in the practice.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. For example the new prescribing team had started to hold team meetings.
- The practice currently ran a GP led telephone triage service in line with a system of Care Navigation that ensured that patients were allocated to the most appropriate clinician. They were enrolled as part of a clinical commissioning group (CCG) pilot in to the scheme and a GP and two senior administration staff were due to attend further development sessions, prior to commencing the pilot.
- The practice were in consultation with the child and adolescent mental health services (CAMHS) to start 'drop in' clinics at the Sidley location.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users.</p> <p>The provider did not ensure that fridge temperatures were recorded with an explanation if found to be outside the agreed parameters or appropriate action taken in response to the findings.</p> <p>The provider did not ensure medicines in the emergency kit are within date and available for use.</p> <p>This was in breach of regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>