The Glebe Practice

Quality Report

85 Sykes Lane
Saxilby
Lincoln
LN1 2NU
Tel: 01522 305298
Website: www.glebepracticesaxilby.co.uk

Date of inspection visit: 30 June 2015
Date of publication: 10/12/2015

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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Glebe Practice on 30 June 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice inadequate for providing safe services. It was rated as requires improvement for being well led and rated as good for providing effective, caring and responsive services. It requires improvement for providing services for, 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 and people experiencing poor mental health (including people with dementia).

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. However the practice had very recently undertaken an audit of many of their systems and processes and were putting action plans in place to address issues raised. These had not yet been implemented and therefore the proposed changes were not yet embedded.
- Not all clinical staff had received appropriate training in safeguarding to ensure they were up to date with current procedures.
- Some staff were not clear about reporting incidents, near misses and concerns and there was limited evidence of learning and dissemination to staff.
- There was not a robust system in place to deal with complaints raised by patients.
- A significant number of patients gave us feedback about the practice and were overwhelmingly positive about their care. They told us they were treated with compassion and dignity.
- Urgent appointments were usually available on the day they were requested. However some patients said that they had to wait a long time to get through by phone to make an appointment.

Summary of findings

The areas where the provider must make improvements are:

- Ensure staff receive up to date training to the appropriate level to ensure safeguarding of vulnerable adults and children.
- Have a system in place to ensure significant events, near misses and complaints are recorded correctly, investigated and any learning cascaded to staff.
- Implement a robust system for dealing with safety alerts.
- Ensure that there are the appropriate procedures in place to ensure the safe storage of medicines.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate and up to date policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that where required staff are covered by an appropriate level of professional indemnity insurance.
- Implement a robust system for recording and actioning medication errors.
- Ensure dispensary staff have either Disclosure and Barring Service checks in place or that it has been risk assessed.
- Ensure all emergency medicines and equipment are in date.
- Have an effective business continuity plan in place to deal with unforeseeable events that may prevent the practice functioning normally which includes mitigating risks and actions, including having a copy available at the branch surgery.

The areas where the provider should make improvement are:

- Ensure adequate arrangements are in place to maintain patient privacy at the branch surgery including privacy curtains in the clinical rooms and glass in consultation room doors are suitably screened.
- Ensure all meetings are minuted.
- Ensure standard operating procedures for the dispensary include a competency section.
- Have in place a robust cleaning schedule to give assurance specific rooms are being cleaned to an appropriate standard.
- Ensure staff are aware of the leads for different areas such as safeguarding and infection control.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

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. There was insufficient information to enable us to understand and be assured about safety. Not all staff were clear about the process for reporting incidents, near misses and complaints. Although the practice reviewed when things went wrong, investigations were not thorough enough and lessons learned were not communicated and so safety was not always improved. Patients were at risk of harm because systems and processes were either not in place or not well implemented in a way to keep them safe. Risks to patients were not always assessed, reviewed or well managed, such as risk assessments relating to the control of substances hazardous to health (COSHH). Not all clinical staff had current safeguarding training at the appropriate level.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and training planned to meet these needs. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. 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 easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they were able to make an appointment with a named

Summary of findings

GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available in one of the surgeries. The practice had responded to issues raised but in some cases learning from complaints was not always shared with staff and some complaints should have been reviewed as significant events.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had recently identified a number of areas where they felt there was room for improvement and had put in place an action plan to address this as part of their strategy going forward. They were in the process of implementing new systems and processes in line with identified areas for improvement. These actions had either not had time to be implemented yet or not had time to be embedded at the time of our inspection but demonstrated that the practice had awareness of the need for change.

There was a leadership structure in place and most staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review and there was more than one policy in place covering some areas such as safeguarding. There was no policy in place for some areas such as significant events. The practice had recently introduced a new cycle of practice meetings which we were told would be minuted. The practice sought feedback from patients and had a recently established virtual patient participation group (PPG). Staff told us they had received inductions and there was a staff appraisal system in place.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as good for being effective, caring and responsive. However it was rated as inadequate for providing safe care and requiring improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were average for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions. The provider was rated as good for being effective, caring and responsive. However it was rated as inadequate for providing safe care and requiring improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people The provider was rated as good for being effective, caring and responsive. However it was rated as inadequate for providing safe care and requiring improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were some systems in place 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 A&E attendances. Patients told us that children and young people were

Summary of findings

treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours. We saw examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The provider was rated as good for being effective, caring and responsive. However it was rated as inadequate for providing safe care and requiring improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had trialled extended hours in order to adjust the services it offered to ensure these were accessible, flexible and offered continuity of care. However some patients felt extended hours would be useful. 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

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as good for being effective, caring and responsive. However it was rated as inadequate for providing safe care and requiring improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 22 out of the 27 patients had received a follow-up. It offered longer appointments for people with a learning disability. We spoke with a relative of a patient with a learning disability who confirmed this.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and most were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as good for being effective, caring and responsive. However it was rated as inadequate for providing safe care and requiring improvement for being well led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

82% of patients diagnosed with dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice planned to implement Mental Capacity Act training for all staff.

Summary of findings

What people who use the service say

The practice had carried out a patient survey of patients in May 2015 in conjunction with the virtual patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The survey showed patients felt they were generally satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the national GP patient survey in 2013 to 2014 showed that the practice was largely in line with local and national averages. For example, the satisfaction scores on consultations with doctors showed that 83% of practice respondents said the GP was good at treating them with care and concern compared with the national average of 85%. It also reflected that 85% of patients would describe their overall experience of the surgery as good which was the same as the national average.

We received 89 comment cards on the day of our inspection and these were overwhelmingly positive about the service experienced. Patients said staff treated them with dignity and respect. Many described the practice as excellent. Comments which were less positive reflected dissatisfaction with getting through to the surgery to make an appointment when it opened, lack of female GP appointments, lack of appointments at certain times and lack of later appointments for people who worked.

.We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We received feedback from three patients prior to our inspection which was generally positive and one patient reflected improvement in the practice in the last year but felt there were issues with some front line staff.

Areas for improvement

Action the service MUST take to improve

- Ensure staff receive up to date training to the appropriate level to ensure safeguarding of vulnerable adults and children.
- Have a system in place to ensure significant events, near misses and complaints are recorded correctly, investigated and any learning cascaded to staff.
- Implement a robust system for dealing with safety alerts.
- Ensure that there are the appropriate procedures in place to ensure the safe storage of medicines.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff have appropriate and up to date policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that where required staff are covered by an appropriate level of professional indemnity insurance.
- Implement a robust system for recording and actioning medication errors.
- Ensure dispensary staff have either Disclosure and Barring Service checks in place or that it has been risk assessed.
- Ensure all emergency medicines and equipment are in date.
- Have an effective business continuity plan in place to deal with unforeseeable events that may prevent the practice functioning normally which includes mitigating risks and actions, including having a copy available at the branch surgery.

Action the service SHOULD take to improve

- Ensure adequate arrangements are in place to maintain patient privacy at the branch surgery including privacy curtains in the clinical rooms and glass in consultation room doors are suitably screened.
- Ensure all meetings are minuted.
- Ensure standard operating procedures for the dispensary include a competency section.

The Glebe 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, two further CQC Inspectors and a GP practice manager specialist advisor.

Background to The Glebe Practice

The Glebe Practice provides primary medical services to a population of around 8160 registered patients in Saxilby, Lincoln and the surrounding area. The practice has a dispensary which dispenses medicines to patients registered with the practice.

At the time of our inspection the practice employed four GP partners, a practice manager, an administration manager, a dispensary manager, four practice nurses, two health support workers, three dispensers, a driver and a team of reception and administration staff.

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

The practice has one location registered with the Care Quality Commission (CQC) which is The Glebe Practice, 85, Sykes Lane, Saxilby, Lincoln, LN1 2NU. They have a branch location at Skellingthorpe Health Centre, 32 Lincoln Road, Skellingthorpe, Lincoln LN6 5UU.

The main surgery is open from 08:30 to 18:30 Monday to Friday and the branch surgery from 08:30 to 13:00 Monday to Friday and 14:00 to 18:00 from Monday to Wednesday. Phone lines opened at 08:00 for appointments.

Appointments were available from 09:00 to 17:00 at the main surgery and from 09:00 to 17:00 at the branch surgery on Mondays to Wednesdays and from 9:00 to 11:30 on Thursday and Friday. Pre-bookable appointments as well as on the day appointments were available and could be booked online, over the phone or in person at the practice. The branch surgery closed for an hour at lunchtime during which time phone lines were diverted to the main surgery. The practice did not offer extended opening hours.

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

NHS Lincolnshire West Clinical Commissioning Group (LWCCG) is responsible for improving the health of and the commissioning of health services for 230,000 people registered with 37 GP member practices covering 420 square miles across Lincoln, Gainsborough and surrounding villages. There are significant health inequalities in Lincolnshire West, linked to a mix of lifestyle factors, deprivation, access and use of healthcare.

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. This 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.

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.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks like for them. These groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We reviewed information from Lincolnshire West Clinical Commissioning Group (LWCCG), NHS England (NHSE), Public Health England (PHE), Healthwatch and NHS Choices.

We carried out an announced inspection on 30 June 2015.

We asked the practice to put out a box and comment cards in reception at both the main and branch surgery to enable patients and members of the public to share their views and experiences.

We reviewed 89 completed comment cards. We spoke with nine patients on the day of our inspection These were overwhelmingly positive and described very good care given by staff who were caring, understanding and responsive.

We spoke with four GPs, a trainee GP, a practice manager, administration manager, dispensary manager, three dispensers, four nurses, a health support worker and five reception or administration staff.

We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Inadequate

Are services safe?

Our findings

Safe track record

The practice did not have a system to robustly ensure incidents, complaints or quality control systems were co-ordinated and shared. It was not apparent that all staff were aware of their responsibilities to raise concerns, or knew how to report incidents and near misses as the four significant events logged over the last year were incidents which involved GPs and the information was only shared at GP partner meetings. Some staff we spoke with were not clear what would constitute a significant event. We saw examples of incidents and complaints that had occurred which had not been reported as a significant event and therefore we could not be assured that the practice could evidence a safe track record over the long term.

The records we looked at relating to significant events, near misses and complaints showed that issues had been considered. However, they had not always been reviewed or investigated in enough depth to ensure that relevant learning and improvement could take place.

Learning and improvement from safety incidents

The practice did not have a clear or robust system in place for reporting, recording and monitoring significant events, incidents and accidents. There was no policy in place for dealing with significant events. There were records of significant events that had occurred over many years and we reviewed the four incidents recorded from April 2014 to March 2015. These all related to clinical GP incidents.

There was some evidence that the practice had learned from these but the findings had not been shared with all relevant staff. None of the staff we spoke with other than GPs could describe any significant events that had occurred within the last year. Significant events were not a standing item on the practice meeting agenda. The practice manager had identified that there was currently no policy or procedure for significant events. We looked at recent meeting minutes which reflected that staff had been shown the template form to be used to report a significant event but there had been no training and no written guidance available for staff. Consequently there was a lack of understanding about what a significant event was and the process for handling them.

The practice did not have a robust system for recording 'near miss' incidents within the dispensary. There was no evidence to demonstrate that lessons were learnt and minimal actions were identified. Conversations which took place with staff following incidents were not documented. We looked at minutes of practice meetings and found that the findings were not shared with management or staff within the practice. We looked at the standard operating procedure (SOP) for dispensing errors. It was not robust and did not give staff enough information on how to act, for example, to complete a significant event form. We spoke with the management team who told us that 'near misses' were discussed but that they did not keep records of discussions held. Therefore we could not be assured that patients were safe. A 'near miss' is an unplanned event that did not result in injury, illness or damage but had the potential to do so.

We saw that the practice had a safety alerts protocol in place. This was not dated and named the previous practice manager as the person to whom alerts should go to. The protocol stated that the process for dissemination was that two copies of any alerts would be printed and one would be placed in the safety alerts folder and one onto the agenda for the next clinical policy meeting. However the practice did not hold a clinical policy meeting.

We saw copies of alerts in the safety alerts folder and each GP had signed to indicate they had read them before they were filed. The alerts we looked at had been dealt with appropriately. We looked at minutes from the GP partners meeting in June 2015 and saw that a new electronic system for Safety Alerts was discussed but had not yet been implemented.

Reliable safety systems and processes including safeguarding

The practice had some systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that some staff had received relevant role specific training on safeguarding. The practice was unable to provide us with evidence of current safeguarding training to an appropriate level for three of the GP partners. Following the inspection the practice manager informed us safeguarding training was planned for the GPs. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to share information but

some staff were unclear regarding the process to follow to do this. We spoke with one staff member who described an incident they had raised which had been investigated as a safeguarding issue.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. Staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. The practice had safeguarding children and adults policies available on the practice computer system. The undated policy relating to children identified the safeguarding lead but stated that staff should report concerns initially to a health visitor .There were no contact details in the policy for relevant agencies. There was a separate policy available which was issued by South West Lincolnshire CCG in August 2014 with contact numbers for safeguarding children and also contact list with names. It was not specific to the practice. We also saw a West Lincolnshire CCG safeguarding adults policy which was due to be reviewed in April 2014 but again was not specific to the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Some reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

Medicines management

The practice did not have a designated GP lead for the dispensary. The dispensary had documents which they referred to as Standard Operating Procedures (SOPs). All staff involved in the procedure had signed the SOPs to say they had read and understood the SOP and agreed to act in accordance with its requirements.

Standard Operating Procedures (SOPs) cover all aspects of work undertaken in the dispensary. The SOP's should consist of step-by-step information on how to execute a task and existing SOPs should be modified and updated when appropriate. Such SOPs would satisfy the requirements of the Dispensary Services Quality Scheme (DSQS). SOPs also provide a basis for training and assessment of competence.

We found that the SOPs did not fully reflect good professional practice, as well as the procedures that were actually performed in the dispensary. The SOPs did not indicate the level of competency expected for each function performed by dispensers. The SOPs had been reviewed and updated in the last 12 months but no reference had been made to any dispensing procedures which had been amended. There was no written audit trail of amendments to SOPs.

Records showed that all members of staff involved in the dispensing process had received appropriate training. We spoke with the dispensary manager who had records to demonstrate that the dispensers' competence had been checked regularly. When we spoke with the dispensary staff they were not aware that their competence had been checked since they obtained their qualifications.

The practice did not have a system in place to assess the quality of the dispensing process. They had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.

The dispensary accepted back unwanted medicines from patients. NHS England's Area Team made arrangements for a waste contractor to collect the medicines from the dispensary at regular intervals. We found that the dispensary had secure containers to keep the unwanted medicines in but there was no records kept of the medicines received by the practice. The practice kept the full containers in the dispensary which is an identified locked area of segregation in line with the requirements of the Hazardous Waste Regulations.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements

because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff in the dispensary were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had not signed up to the Electronic Prescription Service (EPS). The EPS is an NHS service which gives people the opportunity to choose where their GP sends a prescription electronically.

The practice provided a medicines delivery service two days a week for patients registered with the practice. They also delivered urgent medicines on other days when required.

We checked the medicine refrigerators in the main surgery and the branch surgery, including the one in the dispensary and found medicines were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

We looked at the refrigerator temperature records in the dispensary and found that they had not always been recorded daily or actions taken when the temperature went above the advised temperature in line with national guidance to ensure they remained within specified limits.

Similarly the temperature records relating to the refrigerators which held children's vaccinations showed that the temperatures had been recorded above the advised temperature on three consecutive days from 2 to 4 June 2015. The refrigerator which held travel vaccinations also had temperatures outside of the advised range recorded on four consecutive days from 19 to 22 May 2015. The only record of action was that it had been 'reported to admin'.

At the branch surgery evidence suggested that when the member of staff with responsibility for checking the refrigerator temperature was off duty, for example, 19 June and 26 June 2015, the temperatures had not been recorded. Therefore the practice could not demonstrate that the integrity and quality of the medicines were not compromised. The practice did not have a robust cold chain policy to ensure that medicines were kept at the required temperatures or describe the action to be taken in the event of a potential failure.

We looked at records of practice meetings but did not see any evidence that reviews of prescribing data had been discussed.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient.

Blank prescription forms were handled in accordance with national guidance. They were kept securely when received and tracked through the practice.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed staff told us they would be returned to the GP for signature.

We saw evidence of two audits undertaken by the dispensary in 2013, for example, dispensary errors and supplies received from the manufacturer. However they did not contain evidence that changes to treatment or care were made where needed and the audit had not been repeated to ensure outcomes for patients had improved.

We did not see any significant events forms completed regarding medicine errors. However we saw evidence of a significant event meeting which took place in September 2014 in regard to a serious significant error with the controlled drugs register. It was documented that a significant event form had been completed. The meeting minutes described the action to be taken which was that a procedure was to be written to ensure that staff had full guidance on how to receive controlled drugs and a weekly stock check should take place. We looked at the standard operating procedure for the ordering and receiving of a controlled drug. It detailed that two dispensers should enter stock in to the register and initial receipt as described in the meeting held in September 2014.

Cleanliness and infection control

We observed the premises to be generally clean and tidy. The practice employed an external cleaning company. We

saw there was a cleaning schedule for the premises which had been provided by the cleaning company. However this was not detailed enough for specific areas of the practice, for example treatment rooms, and the records seen were not robust enough to provide assurance that individual rooms or areas had been cleaned. There were no formal records of any spot checks having taken place but the infection control lead told us they would implement this.

Patients we spoke with told us they found the practice clean and had no concerns about cleanliness.

The practice had employed an external company to carry out an infection control audit of the main surgery and the branch surgery. This had identified a number of areas which the practice needed to address. We discussed this with the infection control lead who told us they were going to produce an action plan and take the findings of the audit to the next clinical meeting. They had not had the opportunity to do this at the time of our inspection as the audit had been carried out the day before our visit.

One of the practice nurses was the lead for infection control. However staff we spoke with at the branch surgery were unaware who the lead was. The infection control lead attended regular infection control update meetings and were aware of the need to attend further training to enable them to provide advice on the practice infection control policy and carry out further staff training. They told us that there had been no courses available since they took up the lead role. Staff had received induction training about infection control specific to their role and most staff had received annual updates.

The external company who had undertaken the infection control audit had also supplied infection control guidance which included an infection control policy and supporting procedures which were available for staff to refer to, which gave guidance as to how to plan and implement measures to control infection.

There were bodily fluid spillage kits available in the practice and staff we spoke with knew their location and were able to describe how they would use these in line with guidance. There was a policy for needle stick injury and staff told us the procedure they would follow in the event of an injury. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Notices about hand hygiene techniques were displayed in staff and patient toilets at the main surgery but not at the branch surgery. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms at both premises.

The practice had arrangements in place for the safe disposal of clinical waste and sharps such as needles and blades. We saw evidence that their disposal was arranged by a suitable external company.

All cleaning materials and chemicals were stored securely. However at the main surgery the cupboard in which the cleaning products were kept was unlocked although it was in an area which was not accessible to patients. The practice had a control of substances hazardous to health (COSHH) policy in place and information was available to ensure the safe use of these products. However the COSHH information data sheets were not up to date for all the products in use at the branch surgery.

The practice did not have a policy in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice manager showed us a legionella risk assessment for both surgeries which had been carried out on 26 June 2015. The risk assessment had identified issues with the water temperatures at the main surgery and the practice manager told us they were in discussions with their landlord regarding the boiler at the premises to try and rectify this. They also told us that they would be implementing and recording regular monitoring of the water temperatures in the premises in line with national guidance.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example blood pressure measuring devices, and weighing scales.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and

non-clinical staff. This did not include the practice's requirements for Disclosure and Barring Service (DBS) checks or checking that clinicians were registered with the appropriate professional body. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (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). However a DBS check had not been undertaken on all non-clinical staff including those working in the dispensary. There was no risk assessment in place for this. We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

The office manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and staff were flexible in providing cover. We saw that the rotas were prepared up to three months in advance.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We saw that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

At the time of our inspection the practice had limited systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had employed an external company to carry out a health and safety audit on 29 June 2015 which had resulted in an action plan to address identified issues. This included a new health and safety policy and implementation of risk assessments to cover different areas such as slips trips and falls and the control of substances hazardous to health (COSHH). The practice manager was the identified health and safety representative. They showed us the templates they intended to use to carry out risk assessments which would include recording mitigating actions to reduce and manage the risk. We did not see any evidence that risks had been discussed at practice meetings. We also saw that the practice had employed an external contractor to carry out an Electrical Installation Safety assessment at the branch surgery on 23 June 2015. It had been rated as unsatisfactory overall. We spoke with the practice manager who, at the time of the inspection, was waiting for the full report and information on the actions required. Following our inspection the practice manager told us they were awaiting an action plan from the contractor and intended to address the issues highlighted as soon as possible.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment. Records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of both the main surgery and the branch surgery and all staff knew of their location. At the main surgery these included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Anaphylaxis is an acute allergic reaction to an antigen, for example a bee sting, to which the body has become hypersensitive. Hypoglycaemia is a low blood sugar**.** At the branch surgery there were no medicines held for the treatment of cardiac arrest or hypoglycaemia. The practice had not undertaken a full risk assessment and we did not see any evidence of a protocol on how the practice would manage this.

Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. When we checked the anaphylaxis boxes at the main surgery we found some out of date equipment which dated back to 2011, for example, needles, syringes and cannulas. We spoke with the practice manager who immediately arranged for the equipment to be replaced.

Some staff at the branch surgery we spoke with were not aware that the practice had a disaster and business continuity plan in place to deal with a range of emergencies

Inadequate

Are services safe?

that may impact on the daily operation of the practice and we were therefore unable to view the plan at the branch surgery. We looked at the plan which related to both the main surgery and the branch surgery. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. However each risk was not rated and mitigating actions recorded to reduce and manage the risk. The document contained relevant contact details for staff to refer to. For example, contact details of a heating company if the heating system failed.

The practice had carried out a fire risk assessment on 18 June 2015 at the main surgery and on 22 June 2015 at the branch surgery which included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings which showed some evidence of discussion of new guidelines. A recent meeting documented the need for a link on computer system for GPs to access guidance during consultations and we saw that this had been implemented and was being used by the GPs. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The practice manager demonstrated a system which the GPs used which provided useful clinical information and patient information leaflets which could be printed and given to patients during their consultation.

GP's told us that clinical audit results were discussed at the monthly clinical meeting and speakers sometimes came and presented up to date clinical information on relevant topics. These meetings were also attended by the GP trainees.

The GPs told us they lead in specialist clinical areas such as women's health, child health care and coronary obstructive pulmonary disorder (COPD). The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff were happy to ask for and provide colleagues with advice and support. The practice's statement of purpose stated full information about each GP, their background and clinical interests.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital.

Discrimination was avoided when making care and treatment decisions. The culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us five clinical audits that had been undertaken in the last two years. We saw audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice had carried out an audit on bisphosphonates and duration of their use in 2014. This had been carried out as the use of bisphosphonates for longer than five years can be associated with an increased risk of femoral shaft fractures. The practice had identified 143 patients on bisphosphonates on the first audit and of these 45 had been taking it for over 5 years. Those that were on steroids were then excluded. The audit identified a number of patients who could safely have their medication stopped in light of their scan result or duration of use of bisphosphonates and also identified those that would benefit from a DEXA scan who hadn't had one recently. We saw an action plan from June 2015 which noted that as a result of the audit patients had been written to regarding bisphosphonate use for longer than five years, medications taken off repeat prescription and an end date put on prescriptions to ensure medication was not continued inappropriately. There were plans to re-audit in another nine months.

We also saw an audit carried out in June 2015 which looked at 182 patients with atrial fibrillation. These were reviewed in line with NICE guidance and 40 patients were identified who were not receiving anticoagulation. Letters were sent to those patients recalling them for clinical review. We saw an action plan following the audit which showed that patients had been reviewed and medication for some of these patients had been changed. There were plans to re-audit in nine months time.

Other audits seen related to dispensing errors, the treatment of vitamin D deficiency and the outcome of two week wait referrals. There was evidence that prescribing practice had changed as a result of clinical audits undertaken by the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 97.7% of the total QOF target in 2014, which was above the national average of 94.2%. The QOF indicators had highlighted that multi-disciplinary meetings were not taking place. The practice confirmed that these were about to restart.

In the QOF year 2014-2015 the practice had generally reached or exceeded targets. For example:

- Performance for diabetes related indicators was on or above target other than for patients with diabetes who had been given an influenza vaccination.
- All targets for asthma related indicators had been reached.
- Performance for mental health, depression and dementia were all on or above target apart from on indicator relating to dementia blood checks which at the time of our inspection were 59% compared with the 80% target. In this patient group, 89% of patients had up to date summaries and 86% of patients on repeat medications had been reviewed.
- The practice had reached the targets for patients being reviewed since being diagnosed with cancer.
- Performance for heart failure related QOF indicators was better than the national average.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that for example where a patient was on a high risk medicine, it was flagged on the patient's record on the practice computer system and the GP had written next to the prescription when the next blood test was due- this could be seen by both the patient and the GP and helped to prompt review.

One of the GP partners described the system the practice used relating to prescriptions for high risk medication so these were reviewed more carefully. Prescriptions were signed each day by the duty GP.

The practice had recently re-established the gold standards framework meetings for end of life care. It had a palliative care register and the practice had started to minute the palliative care meetings in June 2015, prior to this they had been informal with no records kept. The senior partner told us that as district nurses were based in the building they were able to speak to them to discuss patients as necessary. All the GP partners told us they contributed to the palliative care of patients. We spoke with the complex case manager who told us they found the meetings useful although the practice only had six patients on the register. Palliative patients who were not at the stage where they required end of life care were not included on the register.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as those with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as diabetes and heart failure.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the CCG area in the year 2013-14.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors covering areas such as women's and children's health and including coil fitting and contraception implants. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.)

Good

Are services effective?

(for example, treatment is effective)

Staff undertook annual appraisals that identified learning needs from which required actions were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. However two of the appraisals we looked at recorded issues raised by staff members but there was no record of this being acknowledged or addressed.

The practice was a training practice and two of the partners were mentors. This meant that doctors who were training to qualify as GPs had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with who told us they felt well supported by the partners and involved. They participated in a debrief from the partners after each surgery and were comfortable to ask for advice when they needed to.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles which involved seeing patients with long term conditions such as asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy for dealing with incoming pathology reports and results. Most came via the automatic pathology link which could then be sent for action to the appropriate GP. The partners operated a buddy system to cover each other if one of them was away. We saw that pathology results could easily be reassigned to another GP to enable them to deal with it. Letters were dealt with in the same way, most were received electronically but those received in the post were scanned on to the system.

Out-of hours reports, 111 reports and pathology results were seen and actioned by a GP on the day they were received. We saw that on the day of our inspection there was no backlog. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

A member of staff was responsible for downloading daily hospital admission lists for high risk patients and awaited the discharge summary. When a patient was discharged if they were at high risk they arranged for a GP to contact the patient to see if further care was needed. The list was monitored on a daily basis.

Emergency hospital admission rates for the practice were just below average at 12.3% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We were told that unplanned admissions were reviewed at clinical meetings. The practice had care plans in place for 169 patients who were considered to be at high risk or very high risk of hospital admission.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with end of life care needs. These meetings were attended by district nurses and palliative care nurses. Decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We saw minutes from a meeting in June 2015 after the practice had formalised these meetings. We saw that patient care was discussed and changes to care and actions agreed had been recorded.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

We saw that the practice had a system in place for making referrals and checking that appointments had been made which was working effectively. There was no backlog of dictated referrals as they were completed on a daily basis.

For patients who required home visits there was a policy of providing a printed copy of a summary record for the GP to take with them. The practice had signed up to the

Good

Are services effective?

(for example, treatment is effective)

electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and demonstrated a good knowledge and competency in using it.. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it including relating to Deprivation of Liberty Safeguarding. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had processes in place to deal with this. For example, with making do not attempt resuscitation orders (DNAR). The process recorded that the DNAR had been discussed with the patient and their family if necessary.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw that in the year 2014-2015, 22 of the 27 patients on the learning disability register had been reviewed. Clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The senior GP instructed trainee GPs and staff who chaperoned about Gillick Competency and Fraser Guidelines.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers. Health care assistants ran smoking cessation clinics.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that in 2014-2015, 613 patients had been invited and as a result of this 516 assessments had been completed. This equated to an uptake of 84%, which was well above the CCG average.

There was a process in place for following up patients if they had risk factors for disease identified at the health check and further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice offered nurse-led smoking cessation clinics and there was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 38 out of 74 who had attended the smoking cessation clinic. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 92% in 2014-2015. Three reminder letters were sent out centrally to patients due for cytology screening. There was a process in place for the practice to send non responders a fourth reminder and the patient record was marked overdue and details sent to nursing staff in order to remind patients if they attended the surgery.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was no data available relating to childhood immunisations and no comparative data for flu vaccinations but in the last year the data available showed that flu vaccination rates for at risk groups were:

- 88% for patients with chronic obstructive pulmonary disorder.
- 77% for patients with diabetes.
- 78% for patients who had suffered a stroke.
- 84% for patients with chronic heart disease.

Good

Are services effective?

(for example, treatment is effective)

The practice had a system in place for managing childrens' immunisations and vaccinations and this automatically marked when the patient was next due and a weekly search was run to send out reminders and invites.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015 and a survey of patients undertaken by the practice's virtual patient participation group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from these sources showed patients were satisfied overall with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated well by patients as 85% rated the practice as good or very good, which was the same as the national average. The practice was also largely in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 89% and national average of 88%.
- 87% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%

We received 89 comment cards on the day of our inspection and these were overwhelmingly positive about the service experienced. Patients said staff treated them with dignity and respect. Many described the practice as excellent. Comments which were less positive reflected dissatisfaction with getting through to the surgery to make an appointment when it opened, lack of female GP appointments, lack of appointments at certain times and lack of later appointments for people who worked.

We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We received feedback from three patients prior to our inspection which was generally positive and one patient reflected improvement in the practice in the last year but felt there were issues with some front line staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

At the main surgery disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. However at the branch surgery we saw that none of the clinical rooms had curtains to ensure that patients had privacy when being examined.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that receptionists answered phones in a room behind the reception area. The reception desk was discreet and situated away from the seating area in the waiting room. At the branch surgery the reception desk was separated by glass partitions to aid confidentiality. Additionally, 93% of patients who responded to the national GP patient survey said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

There was a folder available to patients in reception which held information advising patients that violent or aggressive behaviour would not be tolerated and that the practice may take action if necessary. The practice manager told us they had not had any instances of this type of behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed that generally patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 83% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 78% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.
- 91% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.

Good

Are services caring?

- 84% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.

Patients we spoke with on the day of our inspection told us that any health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had enough time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and reflected these views.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were slightly less positive about the emotional support provided by the practice than compared to the average for both the CCG and nationally. For example:

- 83% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Information available in the waiting rooms and on the practice website also told patients how to access a number of support groups and organisations. Carers were identified in the patient record on the practice's computer system although there was no alert to flag them. We were shown the written information available for carers to encourage them to identify themselves as a carer in order to receive support as necessary and offered advice on availability of assessments by social services.

Staff told us that if families had suffered bereavement, a GP contacted them to offer support. And there was a process in place following bereavement to ensure, for example, that any outstanding appointments for the deceased were cancelled.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the virtual patient participation group (PPG).

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to telephone interpretation services were available if they were needed.

The premises of both the main surgery and the branch had been designed to meet the needs of people with disabilities. The surgeries were accessible to patients with mobility difficulties as patient facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. We did observe some areas of paint peeling within the main toilets at the branch surgery.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. We saw there was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice which meant patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning and this was included as mandatory training for all staff. Staff we spoke with confirmed that they had completed the equality and diversity training.

Access to the service

The main surgery was open from 08:30 to 18:30 Monday to Friday and the branch surgery from 08:30 to 13:00 Monday to Friday and 14:00 to 18:00 from Monday to Wednesday. Phone lines opened at 08:00 for appointments.

Appointments were available from 09:00 to 17:00 at the main surgery and from 09:00 to 17:00 at the branch surgery on Mondays to Wednesdays and from 9:00 to 11:30 on Thursday and Friday. Pre-bookable appointments as well as on the day appointments were available and could be booked online, over the phone or in person at the practice. The branch surgery closed for an hour at lunchtime during which time phone lines were diverted to the main surgery.

Comprehensive information was available to patients about appointments on the practice website and in the practice information leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances such as the 111 service. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to eight local care homes as and when they were required and to other patients in their homes who needed a visit. Receptionists had a list for nursing appointments and could allocate longer appointments as required.

The patient survey information we reviewed was mixed in the way patients responded to questions about access to appointments but overall rated the practice well in these areas. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 69% were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 76%.
- 73% described their experience of making an appointment as good compared to the CCG average of 75% and national average of 74%.
- 79% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.
- 70% said they could get through easily to the surgery by phone compared to the CCG average of 78% and national average of 74%.

Patients we spoke with were generally satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their chosen GP. Routine appointments were available for booking two weeks in advance. However the practice did not offer any extended hours opening to accommodate patients who had difficulty attending during normal hours. The practice manager told us they had trialled this but the uptake was poor so had discontinued it.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints procedure was 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 the practice had in place a 'Procedure for recording and dealing with complaints and incidents'. This instructed staff, in the event that a patient wanted to make a complaint, to give them a 'complaint Information Sheet' and record details on a summary sheet and if required to refer to the GP lead. However we asked two members of staff what they would do if a patient wanted to raise a complaint. One said they would ask the Practice manager and the second told us they would give the patient the practice address and ask them to write in with their complaint. This was not in line with the practice's stated procedure.

Additionally the summary sheet we were shown recorded two complaints in the year 2014-2015. This did not correspond to the number of complaints we saw in the complaints folder as we reviewed four complaints which fell within that timeframe.

We saw that some information was available at the main surgery to help patients understand the complaints system. There was a patient information leaflet available containing the complaints procedure which included details of how to raise a complaint with NHS England. There was also a form available for patients to report complaints and a third party consent form included with the leaflet. Staff we spoke with there were not aware of any complaints that had taken place within the practice.

There was not a robust system in place to monitor complaints. Some of the complaints we reviewed had been responded to appropriately and in a timely way but one complaint we looked at from September 2014, which related to a GP's attitude and actions, did not show any details of an analysis of the complaint. Another complaint which was raised a month later in October 2014 and related to the same GP had been reviewed by the lead GP and gave a good analysis and stated that the GPs actions were appropriate. However this was undermined by a clinical entry made on the patient's notes after the complaint had been responded to which contradicted the original analysis.

There was no evidence that complaints had been reviewed to detect themes or trends, for example the two complaints about the same GP within two months. Some of the complaints we reviewed should have also been dealt with as a significant event but this had not been identified. There was no evidence of sharing of learning from complaints in order for all staff to contribute to this and benefit from it with a view to improving patient outcomes or quality of care.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients as they set out in their statement of purpose 'to be a professional and effective team working together to support each other to put our patients care at the heart of what we do'.

The practice were aware of upcoming staffing changes and were considering different strategies to address this.

The practice had recently identified a number of areas where they felt there was room for improvement and had put in place an action plan to address this as part of their strategy going forward. These areas included recognising the need for full clinical audit cycles, reviewing the practice meetings and having more comprehensive meeting minutes, introducing safety alerts in an electronic format, a full overhaul of health and safety and infection control within the practice and more robust reviewing and root cause analysis of significant events. They had very recently employed external companies to carry out a full review of their health and safety and infection control systems and were in the process of implementing new systems and processes in line with identified areas for improvement. These actions had either not had time to be implemented yet or not had time to be embedded at the time of our inspection but demonstrated that the practice had awareness of the need for change.

Governance arrangements

The practice had a number of policies and protocols in place, we saw that these policies and protocols were located on a shared drive on the practice computer system and also in paper format for staff to access. A number of these policies and protocols had no issue or review date.

We looked at 15 of these policies and protocols. Not all of the policies and procedures we looked at had been reviewed regularly. Some were not robust enough, were not consistently written, held incorrect information or were not specific to the practice. For example, we found three protocols in relation to the treatment of Anaphylaxis. It was unclear which the current protocol was or whether all three protocols were to be used. The protocols had no issue date or review date. Each protocol contained different types of information. One of the protocols explained that a system should be in place for checking expiry dates of the contents of the anaphylaxis kit. The protocol did not explain what the practice system was.

Furthermore, a Lincolnshire Community Health Services Cold Chain Policy dated May 2015 was available. This policy was not specific to the practice. The policy did not detail any key personnel or responsibilities within the practice. Neither did it outline any processes which should be in place within the practice or actions to follow in the event that the cold chain was broken. The policy suggested to contact an 'Advisor' should a fridge temperature fall outside of the range of 2-8◦c.

There was no significant events policy in place. There was no evidence of a system to record the dissemination and receipt of policies to staff.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 17 members of staff and they were all clear about their own roles and responsibilities. Most of them told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data that we looked at for 2013-2014 showed that the practice was performing above national standards. QOF indicators had highlighted that multi-disciplinary team meetings were not taking place but the practice confirmed these were about to start.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit regarding atrial fibrillation which the practice had undertaken had identified some patients who were not receiving anticoagulation drugs. Patients were recalled for clinical review and a number of those reviewed had their medication changed. The practice had plans to re-audit in

Are services well-led?

Requires improvement

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

nine months time. There were also processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice had limited arrangements in place for identifying, recording and managing risks. However this had been identified by the practice as an issue and they had taken steps to address it by consulting a number of external companies to audit their processes for infection control and health and safety. These had identified the need for a more comprehensive system of risk assessments, some of which had been carried out such as legionella and fire risk assessments. Others were in the process of being introduced. There was a business continuity plan for both surgeries which we viewed at the main surgery. However when we visited the branch surgery the one relating to those premises was not available. There was no risk log to address and monitor issues such as COSHH, general environment, manual handling, slips, trips and falls.

The practice had recently implemented a three month plan of regular minuted meetings. Minutes we looked at showed that agenda items were appropriate and covered a broad range of topics. This cycle of meetings had not had time to be completed at the time of our inspection. Prior to this records of minuted meetings were limited as we were told that some of the meetings held in the practice were informal and therefore not minuted. We looked at meeting minutes which were available and found limited recording of discussions about performance, quality and risks.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were included in the staff handbook such as those relating to sickness, harassment and disciplinary procedures which were in place to support staff. The practice had recently consulted an external company for support with human resources who were producing a new staff handbook for the practice. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and on computers within the practice.

We asked to see evidence of indemnity relating to clinical staff and the practice were unable to provide this on the day of inspection. We were provided with evidence of indemnity for all clinical staff other than two nurses and two healthcare support workers.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable. Not all staff were involved in discussions about how to run the practice and how to develop the practice as the practice had not held full practice meetings.

We saw evidence that the dispensary team had held a series of meetings in September and October 2014. They identified that weekly meetings would take place. We were not shown any evidence that these meetings had continued after October 2014 and that the issues raised had been fully addressed. For example, staff morale and being part of the practice team. Some staff we spoke with told us they did not feel issues in the dispensary had been resolved and did not feel supported.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through use of their virtual patient participation group (PPG), surveys and complaints received. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The practice manager told us the virtual PPG was still developing and they were trying to recruit more members via their website and notices in the practice. The practice manager showed us the analysis of the last patient survey. The results and actions agreed from these surveys were available on the practice website.

We also saw evidence that the practice had reviewed its results from the NHS Friends and Family Test (FFT) and displayed these results on their website and in the practice. The FFT is a system for gathering patient feedback which asks patients how likely they would be to recommend their practice to friends and family. There is also the opportunity to add comments. The practice was encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through appraisals and discussions. Most staff told us they would

Are services well-led?

Requires improvement

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

not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff we spoke with told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Most of the staff we spoke with told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at seven staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice. We spoke with one of the GP trainees who told us they felt well supported at the practice and had a debrief with one of the partners after every surgery. They told us they would always ask for advice with any consultation that was not straightforward.

The practice had completed reviews of significant events and other incidents and shared some information with other clinical staff when they felt it was appropriate. The significant events we reviewed had all been reported by GPs and it was not clear that learning had been shared with all staff to ensure the practice improved outcomes for patients. Some complaints had clinical implications and should also have been recorded and addressed as a significant event but this had not happened.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The provide must assess and monitor the risks to people's health and safety and do all that is possible to mitigate risks. The provider had failed to have in place suitable arrangements to deal with clinical or medical emergencies. The provider had failed to have in place process for the proper and safe management of medicines, including storage. This was in breach of Regulation 12 (1) (2) (a) and (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must be protected from abuse and improper treatment by the implementation of systems designed to protect service users. Staff must receive safeguarding training that is relevant and a suitable level for their role and updated at appropriate intervals. This was in breach of Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

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. It had failed to ensure effective leadership and governance resulting in practice policies not always being reviewed to ensure their effectiveness and relevance.

The provider did not have in place a robust process to learn from complaints and incidents. They were not discussed at team meetings or with all relevant staff.

This was in breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).