

## Inspection Evidence Table

Nettleham Medical Practice

(1-569342208)

**Inspection Date: 5 and 6 September 2023**

Date of data download: 8 August 2023

## Overall rating: Requires Improvement

At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained some of the good practice, the threshold to achieve an outstanding rating had not been reached. The practice is now rated as Requires Improvement as it failed to ensure systems and processes in place kept people safe.

### Safe

### Rating: Requires Improvement

At the last inspection in July 2016 we rated the practice as good for providing safe services.

At this inspection, we have rated the practice as requires improvement for providing safe services, because the provider was not identifying, managing or responding to risks to the health and safety of service users. We found:

- Recruitment was not always undertaken in line with the provider's policy and staff vaccination records were not maintained in line with national guidance.
- There were gaps in the provider's essential training requirements, levels of training undertaken and completion of training.
- Monitoring and actions related to known health and safety risks were not always carried out, or not carried out correctly or not by an appropriately trained person.
- Risks in relation to infection, prevention and control compliance had not all been identified. The clinical rooms requiring upgrading were subject to a schedule of improvement which at the current pace would take 5 years.
- Safety alerts were not being acted upon appropriately and repeated as required.
- The provider did not have systems in place to assure the staff would be able to respond appropriately to a medical emergency.
- Patients taking regular medicines were not always being monitored or managed in line with national guidance.

- Medicine reviews were carried out without reviewing appropriate safety alerts, reviewing blood results or evidence of recording blood result in patients' records.

### Safety systems and processes

**Some systems and processes to keep people safe were not managed effectively.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>All permanently employed staff had received training in safeguarding. Clinical staff had completed the correct level of training required as per the Intercollegiate Document "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019". Non-clinical staff had completed level 1 training when level 2 was identified as required. Staff working at the practice whilst employed in an Additional Roles Reimbursement Scheme (ARRS) roles had no evidence of any safeguarding training being completed.</p> <p>Following our inspection, we received an updated safeguarding training schedule which included Level 2 training in safeguarding for all staff employed at the practice and evidence that staff had now completed the appropriate levels of training.</p> <p>There were systems to identify vulnerable patients on records. Safeguarding registers had not been corroborated with the local authority (LA) team to ensure they were up to date. Though regular multi-disciplinary meetings with internal and external parties were held.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial

Explanation of any answers and additional evidence:

During our inspection we reviewed a random selection of 5 staff personal files. The provider did not maintain appropriate recruitment records. Issues were identified with the recruitment of 2 of the staff.

1. A locum staff member had not had references taken up as required by the provider's policy.
2. ARRS staff who delivered care to the provider's patients, but were not directly employed by them, had a recruitment file in place with a checklist which included assurance of all aspects of safety for care delivery. The checklists were not fully completed with gaps in training information, details relating to identity of a supervisor or a supervision schedule, employment history, CV, references, proof of identity and professional registrations. Information had been requested by the provider and they indicated the employing commercial organisation had the assurance.

Following our inspection, we received the training matrix for ARRS staff. This identified the ARRS staff were not up to date with training deemed as essential by the provider.

Records of staff vaccination status did not include information relating to the full range of vaccinations identified as required for healthcare staff in The Green Book, published by the UK Health Security Agency. The Green Book provides the latest information for vaccine preventable infectious diseases in the UK.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: July 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: July 2022	Y
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

The practice had an identified lead and policies in place for health and safety, including fire and Legionella. It wasn't always clear that the provider had considered all appropriate risks and checks required.

The main and branch site had comprehensive Legionella risk assessments completed. Both were identified as carrying an overall medium risk of harm, although high risks were also evidenced. Actions had not been taken to mitigate all the medium and high risks.

The branch site had undergone a water hygiene visit in June 2023. Ten areas of non-compliance were identified relating to water temperatures. The areas of non-compliance identified had not been appropriately managed and monitored to ensure patient safety. Water flushing and temperature testing had either not been carried out or was carried out incorrectly by a person who had not undergone appropriate training.

Actions identified by the fire risk assessment had not all been completed at the branch site. A preventative maintenance visit in relation to emergency lighting had been carried out in August 2023, a quote for the works had been received but no date identified to complete the work. Safety checks and required actions were not carried out. For example, we were told there was no fire logbook, fire drills, emergency lighting checks, fire alarm checks, a fire alarm service had not been carried out and no building fire plan had been completed.

Following our inspection, we saw evidence that fire building plans and a fire logbook were now in place. Emergency lighting, fire alarm checks and actions had been completed with an ongoing testing regime in place.

Ligature risks in relation to blind cords had not been appropriately managed or risk assessed to mitigate safety concerns in all clinical areas.

**Infection prevention and control**

**Appropriate standards of cleanliness and hygiene were mostly met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: July 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>A new Infection Prevention and Control (IP&amp;C) lead had been identified 2 months prior to our inspection. They had completed the provider’s essential IP&amp;C training, with more in depth lead IP&amp;C training booked to be undertaken in October 2023.</p> <p>Cleaning at the practice was carried out by an external provider with a service level agreement in place. Communication with the cleaning company was by a communication book and meetings when required, notes were kept of these meetings with actions identified and completed. Cleaning schedules were in use which identified clinical and general areas, these included daily, weekly and monthly tasks. These were consistently completed at the main site but not at the branch site. The provider could not evidence any cleaning had been carried out at the branch site during the week of our inspection.</p> <p>The practice appeared visibly clean and clutter free. The main site was undergoing a scheduled renovation of clinical areas, with 2 clinical rooms completed each year. The issues identified in IP&amp;C audits requiring building works were being addressed during this process. Ten clinical rooms remained in need of renovation and these rooms showed age related issues that impacted on effective IP&amp;C.</p> <p>The sinks and some flooring in rooms awaiting upgrade were not IP&amp;C compliant. Sinks had significant signs of age related deterioration with areas of limescale apparent, carpets were in place in some rooms. The carpets appeared clean, they were vacuumed regularly and deep cleaned on an annual schedule. The issues relating to the pace of the renovation and related IP&amp;C concerns were on the practice’s risk register.</p> <p>Hand hygiene audits were carried out on a regular basis. The provider had purchased a UV Glow Box which identified how good an individual’s hand washing technique was.</p>	

**Risks to patients**

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>A documented process was in place to manage staff absence for each team, this was readily available on the practice’s intranet. The identified daily managing GP partner assisted with management of staff absence and the delivery of care. In the event of short notice staff absence and to minimise the cancellation of pre booked appointments staff worked flexibly and any test results were redistributed to appropriately qualified staff.</p> <p>The provider had an appropriate range of equipment and emergency medicines in place to respond to medical emergencies at the main practice. However, they were kept in 3 separate locations at the main site and were not easily accessible. This could potentially lead to a delay in a patient receiving care in an emergency situation. Following our inspection, we saw photographic evidence this had been remedied with all emergency equipment and medicines located together in an appropriate accessible area.</p> <p>At the branch site, the provider had an appropriate range of emergency equipment in place. However, they did not have the appropriate range of emergency medicines available. Risk assessments had not been undertaken to mitigate the risks associated with the lack of emergency medicines. The provider immediately transported a full range of emergency medicines to the branch site when the issue was highlighted.</p> <p>Staff told us that on occasions equipment was taken from the emergency trolleys, used by staff and not replaced. This meant the provider could not be assured all the required equipment would be readily available in an emergency.</p> <p>Checks of the emergency equipment were carried out weekly. Machines in place to measure a patient’s blood glucose level were not checked for accuracy and did not have evidence of calibration being undertaken. The provider could not be assured any results would be accurate to ensure safe delivery of care.</p> <p>All staff were trained to be able to respond to some medical emergencies. However, 13 out of the 28 non-clinical staff and managers had not completed training to recognise and respond to sepsis.</p> <p>The practice had 3 waiting rooms, 2 at the main site and 1 at the branch site. One at the main site was remote from the reception area and not directly visible to staff to allow monitoring of any patient with</p>	

deteriorating health. We were told the remote waiting room was covered by 2 cameras which displayed footage to screens behind the reception desks. The GPs collected patients themselves so were physically present within the remote waiting room at varying periods when clinics were in progress.

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>As part of our inspection, we conducted a series of searches to assess the practice’s procedures around medicines management and prescribing. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice.</p> <p>Review of patient records, carried out remotely by our CQC GP specialist advisor (SpA) in relation to the clinical searches identified that care records were generally managed in a way to protect patients.</p> <p>A documented process was in place to manage test results. Our GP SpA’s review of clinical searches highlighted concerns with the reviewing and filing of results, we saw 12 abnormal results which appeared not to have been reviewed for over two days. The provider did not have identified timescales to specify expected review of abnormal results. This meant they could not be assured that blood result were managed appropriately, consistently ore measure performance and trends to improve.. We saw evidence of a filed report from July 2023 which indicated a missed diagnosis of a long term condition. The provider reviewed our findings and addressed the issues during our inspection.</p> <p>A system for processing information relating to new patients including the summarising of new patient notes was in place. During our inspection we were told 96 new patient notes awaited summarisation, and that this was 3 weeks’ worth of new patient registrations. The provider had a realistic plan to reduce this following staff absence.</p> <p>The provider implemented safety processes when a decision to refer a patient to another provider for care was made. Changes were made to allow all referrals to be tracked and followed up by creating a task in the clinical system. The task is not closed until a diagnosis is made. Patients also received a message to advise them to contact the practice if an appointment was not received.</p>	

## Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, these were not always effective.

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.27	1.16	0.91	Tending towards variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	9.6%	10.9%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	5.01	5.34	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	224.3‰	222.0‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.36	0.77	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	5.9‰	8.5‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial

The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>During our inspection we reviewed 5 randomly selected Patient Group Directions (PGDs). A PGD is a written instruction for the supply and administration of a licensed medicine in an identified clinical situation, which is signed by a doctor and a pharmacist. A PGD provides a legal framework that allows specified registered health professionals to supply and administer a particular medicine to a pre-defined group of patients. Four of the PGDs reviewed were completed in line with regulation, 1 was not signed on the appropriate date by a doctor. Following our inspection, we were told all PGDs had been reviewed and saw evidence the PGD in question had been amended and was now correct.</p> <p>The practice could demonstrate the prescribing competence of all non-medical prescribers. The Advanced Nurse Practitioners (ANP) were newly qualified and all prescribing undertaken had been clinically reviewed. We saw evidence a regular review by senior GPs of prescribing practice and consultation decisions for ANP and newly employed GPs was in place. Clinical pharmacists working at the practice, including those in ARRS positions, undertook clinical audits of prescribing practice to monitor for any safety concerns or issues.</p> <p>The provider had amended the process in place for medicine reviews within the practice to improve efficiency and minimise the amount of visits a patient with multiple comorbidities may need to make to the practice. An initial review of a patient's prescribed medicines was undertaken by a clinical pharmacist in the month of the patient's birth, tasks were then sent to all staff who needed to be involved in the medication review to identify any monitoring needs, issues or concerns before a patient was requested to attend the practice. This meant the patient attended the practice once for review of all medical conditions and monitoring requirements. Clinical searches showed this process was not always effective. We saw evidence medicine review codes had been added to patient records without documented evidence of the review taking place and that monitoring was overdue.</p>	



Whilst the prescribing data for antibacterial prescription was higher than the local and national averages it was reflective of the patient demographics. The practice had introduced a pop up reminder to the clinical system each time antibiotics were prescribed to remind staff to review appropriateness. Trend analysis was undertaken which led to ongoing monitoring of prescribing practice and improvements.

There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines. The process included pop up reminders and an automatic reminder to staff who manage the recall system. This was not always effective. For example:

- The practice ran searches on a 3 monthly basis to identify patients on medicines which required regular monitoring and a shared care protocol was in place with an acute hospital. The 3-month search schedule risked patients not being identified in a timely manner.
- As part of the inspection we conducted clinical searches. A search of patients prescribed Azathioprine, a DMARD medicine (DMARD medicines are a class of drugs indicated for the treatment of inflammatory disease) showed that 3 out of 23 patients prescribed the medicine had not had the required monitoring in the last 6 months and one patient was prescribed a combination of drugs that may be unsafe. It is recommended that monitoring is undertaken every 12 weeks. Review of patient records showed that shared care agreements were not always in place. Review of a different DMARD medication identified that MHRA safety alerts were not always being responded to effectively by staff.
- The provider was not able to demonstrate that it remained safe to prescribe medicines to all patients where specific, frequent, monitoring was required. The provider did not have a system in place to obtain, review and record blood test results for patients' who had tests carried out at hospitals outside the local area.
- The clinical searches identified a total of 475 patients prescribed a medicine which may be used to prevent blood clots forming. Of these we identified 11 patients who may be overdue appropriate monitoring. We sampled 5 of these and found 4 patients did not have timely blood results, annual height and weight checks documented which were required to allow safe calculation of medicine doses. One patient was identified as being at risk of clinical complications as blood test results showed the medicine was contraindicated and this had not been identified at the documented medicine review. We were told the practice had their own template for review which included calculating the correct medicine dosage with up to date information that was not directly inputted into patient records.
- The practice's review template did not link to patient safety alerts, this meant safety alerts in place for the medicine were not reviewed by staff during the reviews. The clinical searches identified a total of 49 patients prescribed a specific medicine which may be used to treat conditions by reducing activity of the immune system. Monitoring of these patients' blood tests should be in place every 12 weeks. Clinical searches showed 15 patients had not been monitored appropriately.

The practice ran searches on a 3 monthly basis to identify patients on medicines which required regular monitoring and a shared care protocol was in place with an acute hospital. The 3-month search schedule risked patients not being identified in a timely manner in the event of errors.

The practice monitored the prescribing of Controlled Drugs with audits. It had been identified that opiate (opiates are medicines that can be addictive) prescribing had increased, and the provider managed this with individual patients. An agreed contract was developed between the practice and the patients which had successfully improved the prescribing rate.

Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective at the main site. The monitoring of the vaccine storage refrigerator at the branch site was undertaken 4 days a week when a nurse was on site. An alarm was triggered to alert staff if the temperature of the fridge had been outside the safe temperature range. A data logger was in place to monitor the refrigerator temperature continually, this was routinely downloaded monthly and after any alarm triggers to ensure the safety of stored medicines.

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Dispensary services	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The provider took part in the Dispensary Services Quality Scheme (DSQS). The DSQS is a voluntary scheme with a range of quality standards and audits for a dispensing practice to work to, this improves patient safety and care. For example, an audit undertaken into the provision of blood thinning medicines had been completed and led to improvement in the care of 7 patients and a reaudit was planned for 2024.</p> <p>The practice had Standard Operating Procedures (SOP) which covered all aspects of the dispensing process which were regularly reviewed. Not all staff had signed the SOPs with 6 signatures out of 8 outstanding on the day of our inspection.</p> <p>All dispensary staff had documented competency checks carried out annually prior to appraisals and qualification checks completed.</p> <p>Review of items dispensed over 5 separate months showed over 41,000 items were dispensed in that period. Between July 2022 and June 2023 the provider identified 18 dispensing errors across a range of dispensing areas. We saw evidence the errors and near misses were discussed with the individual as well as in pharmacy and practice management meetings.</p>	

A weekly mentoring session between the clinical pharmacy lead with a GP was in place to ensure any concerns and difficulties could be discussed. The partners and practice manager were always available and approachable to escalate any issues as required.

Dispensary leaders attended regular monthly meetings to discuss issues and concerns. These included dispensary meetings, clinical meetings, respiratory team meetings, significant event meetings, and team leader meetings. Pharmacy meetings had minutes taken but did not include a list of attendees or apologies. The provider could not be assured which staff had received the information discussed.

**Track record on safety and lessons learned and improvements made**

**The practice learned and made improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	10
Number of events that required action:	10
Explanation of any answers and additional evidence:  Staff we spoke with, completed staff questionnaires and minutes of practice meetings reviewed showed significant events and complaints were discussed and action and learning were disseminated. A regular newsletter was produced, and all staff received a copy.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Child prescribed inappropriate medication for a childhood illness.	Individual prescriber reviewed appropriate NICE Guidance to update on and adopt current best practice.
Patient incorrectly given Covid vaccine 9 weeks after having previous one instead. Guidance is 12 weeks.	Discussed with all staff and reminder issued to check all vaccinations prior to administering. Covid vaccine clinic format changed to mitigate risk.
Hospital letter attached to incorrect patient and issued incorrect medication, letter who the correct patient was for was not registered with practice.	Staff reminded to search by DOB or NHS no. instead of name, stickers have now been placed on all monitors reminding of this. Duty of candour was undertaken.
Patient very abusive to staff at reception.	Changes made in security and all staff made aware of the incident and changes.

<p>A clinician cancelled an electronic prescription on the system, but the patient still received the medication. This was due to the fact the pharmacy had already downloaded the prescription. This means the only way to cancel a prescription is to contact the pharmacy directly.</p>	<p>Following this incident, the decision was made that all rejected cancellations are sent to the clinical pharmacist team for review – this means, if necessary, an intervention can be made, and the pharmacy will be contacted ensuring that the medication does not reach the patient.</p>
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Safety alerts	Y/N/Partial
<p>There was a system for recording and acting on safety alerts.</p>	<p>Partial</p>
<p>Staff understood how to deal with alerts.</p>	<p>Partial</p>
<p>Explanation of any answers and additional evidence:</p> <p>A system for recording and acting on safety alerts was in place, and responsibility sat with senior GPs and managers, this was not always effective. The provider was unable to demonstrate that all relevant safety alerts had been responded to appropriately. We saw that:</p> <ul style="list-style-type: none"> <li>• The Medicines and Healthcare products Regulatory Agency (MHRA) circulate safety alerts which identified concerns and actions required by healthcare staff to mitigate risks to patients. We saw that not all MHRA alerts at the practice had been actioned. For example, an alert from September 2020 relating to adding the inclusion of a date of administration for a weekly medicine had not been implemented.</li> <li>• Patients remained on medicines that increased the risk of birth defects in females of childbearing age without anything in their records to indicate this had been identified, the risk discussed with the patient or adequate contraception considered.</li> <li>• The practice had not uploaded the required pregnancy prevention plan or annual risk assessment forms to their records which is a requirement for females of childbearing age prescribed sodium valproate.</li> <li>• Reviews of MHRA alerts were not repeated to identify new patients who may be at risk of harm.</li> </ul> <p>During our inspection the management team told us they were changing the process to how safety alerts are monitored and managed.</p>	

## Effective

## Rating: Good

At the last inspection in April 2016 we rated the practice as outstanding for providing effective services., because:

- The practice had an on-going audit programme in place, demonstrated quality improvement, provided care based on evidence-based guidance, completed audits to monitor end life care and reviewed deceased patient care to identify any improvements required.

The practice is now rated good for providing effective services because the provider did not have appropriate systems in place to ensure effective care.

We found:

- Patients with long term conditions, undiagnosed conditions or had experienced an exacerbation of asthma were not always being monitored, identified or managed in line with national guidance.
- Current legislation and evidence based guidelines were not always embedded in the pathways.

At this inspection, we had changed to an inspection process which included clinical searches of the practice IT system of patient records to identify any issues with care. We also found that those areas previously regarded as outstanding practice were either no longer in place at the practice or now delivered by more GP practices.

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

#### Effective needs assessment, care and treatment

**Patients’ needs were assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients’ treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients’ needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
The practice had systems and processes to keep clinicians up to date with current evidence-based practice. Safety alerts were not always embedded within the practice pathways to provide prompts to clinicians to review	

care against current evidence-based practice. This meant action was not always being taken in relation to safety alerts.

## Effective care for the practice population

### Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice demonstrated they had a system to identify people who misused substances.
- Patients living with non-complex mental health issues such as anxiety and depression filled in an annual questionnaire which incorporated recognised scored assessments to allow a patient's condition to be reviewed. These were initially reviewed by a clinical pharmacist who then, dependent of assessment scores either tasked a clinician if further review was indicated or continued on going treatments
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- A mental health practitioner was available on site each week and in some extended hours clinics up to 8pm and on a Saturday.
- Patients suffering from hearing loss could book into the provider's nurse led hearing clinic for review, treatment or onward referral for an NHS hearing test at the local hospital.
- A fully comprehensive family planning service was in place to patients from the practice and surrounding practices which included advice and prescriptions for all types of contraceptive pill, as well as the fitting of coils, and implants.
- The practice offered clinics dedicated to patients with skin conditions. The clinic was supported remotely by specialists in secondary care who reviewed photographs of the concerning problem, taken with a high quality specialist camera and provided advice.
- The practice offered a nurse led cryotherapy treatment for non-cancerous skin lesions.
- A chaplaincy service was available at the surgery to support patients.
- A facility to patients to take their own blood pressure was available in the surgery without appointment.
- The practice had a Neighbourhood Triage Practitioner identified who helped the most complex and vulnerable patients to deliver a holistic assessment which included multiple health and social care workers.
- Social prescribers worked with patients from the practice to assist with practical help and allow patients to live the life they wanted.
- The practice was accredited as Armed Forces Veteran Friendly, there was an identified lead and staff had undergone training to support patients who had served in the armed forces.

## Management of people with long term conditions

### Findings

As part of our inspection, we conducted a series of searches to assess the practice's procedures around medicines management and prescribing. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice.

Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance:

1. Patients requiring high dose oral steroid treatment for exacerbations of asthma were not always followed up in line with national guidance to ensure they received appropriate care. A random sample of 5 patients' records from the 183 who had received 2 or more courses of rescue steroids in the last 12 months were reviewed and all 5 records had issues regarding care:
  - There was no evidence 3 of the 5 patients had received a steroid card when appropriate.
  - Three of the 5 patients were overdue an annual asthma review.
  - One patient had been issued high dose steroids as a repeat prescription with no review of the patient's condition at point of issue to allow a clinical baseline to assess effect and ensure safety.
  - One patient had not been followed up following exacerbation of asthma or had safety netting documented in records in line with guidance.
2. Nine patients with blood tests indicating they may have an undiagnosed long-term condition which had not been identified or recorded in their records were identified. We saw evidence the provider had reviewed these records, contacted the patients and identified this as a significant event as a result of our inspection.

Clinical searches identified 41 patients with diabetes who already had a complication associated with this condition, also had a significantly poor blood glucose control when last tested. A random review of 4 of the 41 patients showed effective follow up and treatments had been implemented in discussion with patients.

Clinical searches identified that 609 patients were living with hypothyroidism. Monitoring of the condition should take place every 12 months. One patient had not been monitored for over 18 months and the remaining had undergone thyroid function test monitoring in the previous 18 months. The patient over the 18-month period had an appointment in place for the test to be carried out at the time of our clinical search.

We saw there were 45 patients with Chronic Kidney Disease Stages 4 or 5, the searches identified that all patients had been appropriately managed.

Patients with long-term conditions were mostly offered an annual review to check their health and medicines needs were being met. Patients experiencing an exacerbation of asthma had not all received an annual health check.

A GP clinical lead was identified for all long-term conditions.

For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

All residents of care and residential homes registered with the practice had care plans agreed and in place.

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Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	110	112	98.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	87	90	96.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	87	90	96.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	86	90	95.6%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	105	109	96.3%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	73.2%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	78%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years)	81.9%	N/A	80.0%	Met 80% target



for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	49.2%	58.1%	54.9%	No statistical variation

### Any additional evidence or comments

The provider had links on the practice website to specific services for children and young people. These included services available up to 19 years of age, children's centres, emotional wellbeing and behaviour online pathways and a mental health support group specifically dedicated to young people.

### Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past 2 years:</p> <p>The provider had a programme of targeted quality improvement and carried out a suite of audits at varying intervals relating to 50 different health conditions as well as ad hoc audits to inform about care and treatment to make improvements. These included, long-term condition follow up, medicines, specific conditions and the use of chaperones.</p> <p>We saw evidence of actions, discussion at staff meetings and improvements following audits. For example, improvements were made in the use and coding of chaperones, prescribing practices, care for patients in the final year of life and changes in the way patient's living with a gynaecological condition were followed up on a long term basis.</p> <p>An audit related to the prescribing of opiates showed an increase in usage among patients. This led to a review of all opiates prescribed and the development of processes which successfully helped patients to reduce consumption.</p>	

**Effective staffing**

**The practice was able to demonstrate that staff mostly had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a programme of learning and development. Training for staff related to patients living with learning disabilities and autism had become a mandatory requirement from 1 July 2022 for registered health and social care providers. At the time of our inspection 4 members of staff out of the 53 employed had completed this.</p> <p>Gaps in training for employed staff and those working in Additional Roles Reimbursement Scheme (ARRS) positions were evident in relation to sepsis, learning disability and autism, safeguarding and inappropriate levels of training for some staff. Staff did not have protected time (PLT) for learning and development at the time of our inspection and completed training in an ad hoc way when demand allowed. We saw evidence that changes had been made to the way the practice ran, to reintroduce protected learning time from September 2023 where a focus on the provider essential training was to be prioritised at PLT.</p> <p>Speciality clinical staff had the skills, knowledge and experience to carry out their roles.</p> <p>The provider could demonstrate the competence of permanently employed staff in advance clinical practice. Staff employed in ARRS roles had not completed the practice expected mandatory training. The Advanced Nurse Practitioners were newly qualified, and all decisions had been clinically reviewed. We saw evidence a regular review by senior GPs of consultation decisions for ANP and newly employed GPs was implemented.</p> <p>Clinical pharmacists working at the practice, including those in ARRS positions undertook clinical audits of prescribing practice to monitor for any safety concerns or issues.</p> <p>The practice was accredited with The East Midlands Healthcare Workforce Deanery as a training practice for registrars training to become GPs and with The University of Nottingham. We saw evidence of training plans, monitored practice, audit and feedback for the trainees at the practice to ensure safe care delivery and effective learning.</p>	

Staff had access to regular appraisals. Of the 32 due appraisals, all had been undertaken within the previous 13 months. Staff told us they were well supported to meet the requirement of professional revalidation.

### Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and treatment.**

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff from partner organisations working with the practice in research and training projects provided positive feedback. They described a forward thinking, professional, dedicated approach to improving patient care by the practice team. It was stated practice staff were quick to respond to any queries, good at working in partnership, patient focused and encouraging to other sites by mentoring research naive organisations.</p> <p>We received positive feedback from managers of care homes looked after by the practice. A named GP was assigned to each organisation and attended weekly; alongside this the on-call GP was available to visit as required.</p>	

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p>	

The practice supported national priorities and initiatives to improve the population’s health. Patient information was available on the practice website. Though waiting rooms did not have a wide range of information leaflets for patient without digital access.

**Any additional evidence or comments**

Testing kits were discreetly available for patients to access in reception areas to give anonymous access allowing them access to diagnose a common sexually transmitted infection.

**Consent to care and treatment**

**The practice always obtained that it always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>We reviewed 5 randomly selected patient records where a DNACPR decision had been recorded. Of these 2 were completed in secondary care and 1 by a district nurse and countersigned by a GP. Nothing was available to review in the 2 records completed in secondary care. Whilst the DNACPR completed by the District Nurse was not available on the system, comprehensive documentation was completed within the patient record which showed compliance with legislation.</p> <p>The 2 DNACPR decisions completed by practice staff showed they complied with relevant legislation and were appropriate. One of these records did not have all the information required on the DNACPR form but it was recorded in the patient record.</p>	

**Caring**

**Rating: Good**

The data and evidence we reviewed in relation to the Caring key question as part of this inspection did not suggest we needed to review the rating for Caring at this time.

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
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Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:  During our inspection we requested feedback about care from patients. We received 15 comments of which 11 were positive and 1 was mixed. The 3 negative comments related to availability of appointments with GPs, continuity of GP and Ask my GP operating times.	

Patient feedback	
Source	Feedback
Feedback from patients.	A frequent user of Nettleham Medical Practice with several medical conditions confirmed they were always treated with great care, expertise, dignity and kindness by both clinical and non-clinical staff. Had no problem accessing appointments and the practice staff rang to state when a non-urgent appointment would be available. Communication was described as good, and the use of social media was excellent and seemed greatly valued by the village. They felt the practice's involvement in research and training was valuable to broaden staff's exposure to wide ranging issues and improved the service and care available.
Feedback from patients.	Good practice but need more nurses not GPs.
Feedback from patients.	The booking system and enquiries via the patient portal saved time trying to ring or visit the surgery for information, advice and appointments. The staff were excellent and provided a high level of service from the reception team to front facing practitioners. The services through the very challenging time of COVID were very good. Follow up and continuing healthcare for myself who required ongoing treatments was provided.
Feedback from patients.	Dr Williams and his staff are always quick to respond, always polite and attentive. Dr Williams and his staff are professional and friendly at all times. They make time to listen to concerns. The treatment received is excellent. I have no complaints and can only compliment Dr Williams and his team on the care they deliver!
Feedback from patients.	Concerns related to Ask My GP availability and continuity of GP, telephone waiting times and waits for appointment to see GP.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	85.4%	84.1%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a	86.9%	83.8%	83.8%	No statistical variation

general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	95.9%	93.3%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	73.9%	71.0%	71.3%	No statistical variation

### Involvement in decisions about care and treatment

**Staff helped patients to be involved in decisions about care and treatment.**

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Easy read materials were available in large print and a variety of languages.</p> <p>A dedicated carers section was available on the practice's website with links to a large variety of resources to provide assistance. This included financial, legal and practical support.</p> <p>The practice had a chaplaincy service in place which patients could book appointments via the providers online booking system. The chaplains were specially trained to work in general practice to offer help and support to patients as required either whilst a patient was waiting for counselling, support or on a standalone basis.</p>	
Source	Feedback
Feedback from patients.	All staff were always quick to respond, polite, attentive, professional and friendly at all times. Communication was good and staff made time to listen to any concerns. Treatment received was described as excellent. Patients stated they can only compliment the care delivered by the practice.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	97.2%	90.2%	90.3%	Tending towards variation (positive)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Partial
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:  The practice had 3 waiting rooms, 2 of which had a small range of information leaflets for patients to inform on how to access support in some areas, the third had no leaflets or information in place.	

Carers	Narrative
Percentage and number of carers identified.	694 carers on the practice register which is 5.5% of the practice list.
How the practice supported carers (including young carers).	<p>Both carers and the cared for were identified as such on the practice IT system to ensure staff were aware.</p> <p>The practice had a range of resources for carers which included details of support agencies available in numerous formats. These included notice boards, written information, TV presentation in some waiting rooms, questions on new patient forms, a section on practice website and the electronic check in screen.</p> <p>Two carers' champions were identified, and all staff had undertaken carers awareness training.</p> <p>All carers were provided with a carers pack which included contact details of helpful organisations.</p> <p>The practice was accredited with the Lincolnshire Carers Quality Award "You Care we Care" which is awarded to practices who have successfully demonstrated their commitment to Carers.</p>

How the practice supported recently bereaved patients.	An alert was added to a bereaved patient's records to ensure all staff were aware and a bereavement letter and chaplaincy support booklet was sent. Chaplaincy support was available at the surgery and could be booked online.
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### Privacy and dignity

#### The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:  During our inspection we saw a member of staff left their access card in a computer when they had left the room. This meant any staff in the area could see the patient identifiable data on the screen and did not ensure privacy.	

## Responsive

## Rating: Good

### Responding to and meeting people's needs

#### The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:  The facilities and premises were appropriate for the services being delivered and reasonable adjustments were in place to allow physical access to services for all patients living with specific needs.	



A volunteer driver scheme was in place, the purpose was to allow patients who had difficulty attending the surgery to be collected for appointments and if needed to transport to other care providers for any ongoing treatment. A medicines delivery service was also in place to for patients unable to collect their prescriptions.

Patients had told the practice they had difficulty contacting the service by telephone. The provider had made changes to the current telephone system and the way staff worked to improve the situation. A replacement telephone system was in the process of being introduced.

Ask My GP was available from 6am until 10 am Monday to Friday to allow patients remote access to appointments. Patients could contact the service by telephone if they did not have digital access and outside the times Ask My GP was available. Patients could request to see a specific clinician if required and details of clinician’s availability were included in the appointment information available.

<b>Practice Opening Times</b>	
<b>Day</b>	<b>Time</b>
Opening times: Nettleham Surgery	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 8pm
Friday	8am – 6.30pm
Opening Times: Cherry Willingham Surgery	
Monday	8.30am – 12.30pm
Tuesday	8.30am – 12.30pm
Wednesday	8.30am – 12.30pm
Thursday	8.30am – 12.30pm
Friday	8.30am – 12.30pm

**Further information about how the practice is responding to the needs of their population**

Patients had a named GP who supported them in whatever setting they lived.

The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

In recognition of the religious and cultural observances of patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families’ wishes when bereavement occurred.

A home visit service was in place for patients which included both vaccinations and phlebotomy for patients living with mobility issues.

The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

Additional nurse appointments were available until 8pm on a Thursday at the practice and at other local practices each weekday evening so school age children did not need to miss school.

All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

The practice was open until 8pm on a Thursday and all day one Saturday every 2 months. Pre-bookable appointments were also available to all patients at additional locations within the area up to 8pm and each Saturday as the practice was a member of IMP Primary Care Network (PCN).

The dispensary stayed open until 8pm on a Thursday to support extended access at the practice.

The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.

People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. The practice address could be used for both registration and correspondence.

The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

#### People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y

Explanation of any answers and additional evidence:

All appointment requests were reviewed on the day and clinical concerns were triaged by the duty doctor. Patient appointments were made according to the identified clinical need. Urgent appointments were allocated on the day or the following day depending on capacity and demand. Routine needs were divided into 2 streams with different schedules of appointments made available to patients depending on the outcome of the clinical review.

The practice recognised the increased activity and demands following a bank holiday and amended the capacity to increase the amount of on the day appointments to minimise patient wait times.

Patients had timely access to appointments. We reviewed the GP Appointments Data (GPAD) Dashboard which provided unverified data, relating to the number and type of appointments that had been completed by GPs and Advanced Nurse Practitioners (ANPs). In July 2023, it was identified there had been a total of 6,507 appointments of which 70% had been face to face and 27% had been via the telephone.

**National GP Patient Survey results**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	46.5%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	57.3%	57.5%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	62.5%	55.0%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	84.4%	76.1%	72.0%	Tending towards variation (positive)

Source	Feedback
NHS.uk website (formerly NHS Choices)	Review of NHS.uk website showed 9 reviews between June 2022 and July 2023.

	Of these reviews 3 were overwhelmingly positive and the remainder were negative due to access to routine appointments, telephone waits, communication and lack of continuity of GPs.
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### Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	28
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Examples of learning from complaints.

Complaint	Specific action taken
Numerous complaints about how slow the practice is at answering phone calls.	Changes to telephone system to be made to include call back feature due to go live September 2023. Internal changes to how the reception team were organised made to try and improve the speed the calls are answered. Further review of telephone systems was under way.
A comment from a patient that there are not enough chairs with arms in the waiting room.	A plan was put in place to purchase more chairs.
Concerns related to practice staff understanding the needs of transgender patients.	Two GPs undertook training a practice policy was developed and e-learning training is available for staff.
Patient complained signage at practice was poor.	Signage reviewed and was replaced.

**Well-led**

**Rating: Requires Improvement**

At the last inspection in July 2016 we rated the practice as Outstanding for providing well-led services because:

- The practice had a clear vision and strategy to deliver high quality care, a clear leadership structure and staff felt supported, arrangements were in place to monitor and improve quality and identify risk, processes were followed to comply with duty of candour, there was a culture of openness and honesty, systems were in place to manage safety alerts and there was a strong focus on continuous learning, training and improvement at all levels.

At this inspection, we found that those areas previously regarded as Outstanding practice were now embedded throughout the majority of GP practices.

At this inspection in September 2023 we have rated the practice as Requires Improvement for providing well led services. We found:

- Leaders demonstrated that they had the capacity and skills to lead the service, but work was required to improve systems and processes in order for them to improve oversight of the whole practice. The overall governance arrangements were not effective in all areas.
- There were gaps in systems to assess, monitor and manage risks to patient safety.

**Leadership capacity and capability**

**There was compassionate, inclusive leadership at all levels. The leadership was not always fully effective.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Leaders understood some of the challenges facing the practice and had identified strengths, weaknesses and some risks to the practice. Actions had been taken or were underway to mitigate the risks identified. For example, strategy was identified as a key weakness, and this led to changes in the way the leadership was organised.</p> <p>The provider had made changes to the way the administration team worked in response to patient feedback relating to telephone waiting times. They had also made changes to the telephone system and a ring back facility had been introduced to help improve patient access. A new telephone system was being introduced when the contract with the current provider ended, this would allow the provider to review data relating to call waiting times and abandoned calls. This would also help the practice identify performance issues and make changes to improve the service.</p>	

Leaders had recognised some issues relating to compliance and this had led to a review of staff roles with a compliance manager identified a few days prior to our inspection visit. Leaders had not been aware of all the compliance issues and risks identified at our inspection.

Oversight by the leaders and practice manager of the systems and processes at the branch site was poor. Whilst the GPs attended the site on a regular basis the management team attended less often. This had led to a lack of understanding of the amount of issues identified to quality and safety specifically at that site.

All staff we spoke with told us that leaders were visible and approachable. Staff told us they felt the leaders genuinely cared about them and would be happy to approach them with any issues, concerns and ideas.

Following recent changes in the GP team, a review of the management structure in place was undertaken. This led to changes in the way the management of the practice was undertaken. A Senior Leadership Team (SLT) model was introduced. This meant there was no overarching lead GP partner, and all partners took responsibility for different areas. Succession planning and leadership development was ongoing.

**Vision and strategy**

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
The vision, values and strategy were developed in collaboration with staff 9 years ago. Review of the vision, values and strategy had not been undertaken since.	
All staff we spoke with knew and understood the vision, values and strategy and their role in achieving them.	

**Culture**

**The practice had a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y

When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>A staff wellbeing policy was in place and all staff had access to an Employee Assistance Programme (EAP). The EAP included access to practical and psychological support for both employees and their households.</p> <p>We received feedback from or spoke with 11 staff during our inspection and all told us they felt able to raise concerns without fear of retribution, and there was a strong emphasis on the safety and wellbeing of staff and patients. Staff recounted examples of when managers had assisted with both work related and personal issues with occupational health services available if required.</p> <p>Staff described the practice has having a culture of excellence, interest in providing good care, supporting staff in their roles and of having an enthusiasm for teaching.</p> <p>We saw evidence that duty of candour was carried out when things went wrong, and that people affected were given an apology and informed of resulting action. We saw documented evidence of how this worked in patients records and complaint responses.</p>	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff	Leaders and managers listen to any issues staff may have both personal and professional they will make adjustments and changes to try to accommodate needs in the smoothest way. It makes you feel valued, and they care.
Staff	The team I work with are amazing and the management support is excellent. We make a difference and offer a really good service. Some patients can be rude and abusive, changes have been made to allow this to be dealt with.
Staff	I really enjoy and I am proud to work for Nettleham medical practice. I enjoy the fast pace of primary care and being able to offer my support. Nettleham have a whole team spirit, we are one, and all work together through some very busy days/weeks/months. We have lovely patients who know most of us and it's a family feel practice, I am proud to work here and after being a patient at the practice before starting my working life here, know how good we are the other side of the counter.
Staff	Following staff feedback changes were made to GP roles, the on call job load altered to help with the on call workload and debriefing times.
Staff	Amazing nursing team, my work family we all always put the patients first.

**Governance arrangements**

**Systems were not always effective to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Not all governance systems had been working effectively. During our inspection we found a lack of oversight in some areas. We found issues relating to safeguarding, training, recruitment, staff vaccination records, infection prevention and control, safety monitoring of the premises, fire procedures, emergency equipment and medicines, medicine reviews, management of safety alerts, condition monitoring and follow up and risk identification.</p> <p>The practice took part in the NHS Accelerate Programme (NHSAP) between August and December 2022, NHSAP looks at innovation to improve patient care and improve staff experience. Following an away day for the senior team at the practice facilitated by the staff from the (NHSAP) in May 2023 a review of Governance structures and systems was undertaken. This led to a collaborative approach to management and governance being adopted.</p>	

**Managing risks, issues and performance**

**Processes for managing risks, issues were not always effective.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had developed a risk register that was to be added to the set agenda for review at the monthly SLT meetings.</p>	



During our inspection previously unrecognised risks were identified to the provider. Once these were discussed immediate resolution where possible was undertaken. Following our inspection, we received evidence that actions had been taken or commenced to address the identified risks.

**Appropriate and accurate information**

**There was a demonstrated commitment to using data and information proactively to drive improvement and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	

**Governance and oversight of remote services**

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner’s Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

**Engagement with patients, the public, staff and external partners**

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an active Patient Participation Group (PPG). Meetings had temporarily ceased during covid but were now in place on a 3 monthly basis. Representatives from the practice attended and acted on views to improve the service and culture. Money raised through a variety of fund-raising activities by the PPG had been utilised to provide items for the practice to improve patient experience.</p> <p>The PPG provided a voluntary transport service to patients, this had been in place since 2009. The service was formed in response to difficulties patients experienced in attending consultations and collecting medicines. Over 100 patients a week benefited from this service.</p>	

Feedback from Patient Participation Group.

Feedback
<p>A member of the PPG told us they felt the provider was supportive of the group and valued the input they gave to patient care. They said the provider listened to comments and feedback that they informally gathered from patients. We were told about a situation with a patient due to be collected who was unwell and unable to contact anyone, a driver reported this, and action was taken to ensure the patient was safe.</p>

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence	

Examples of continuous learning and improvement
<p>The practice was accredited as a research practice and were actively involved in a variety of different research projects through various different organisations. In the year from April 2022 to April 2023 the practice was the highest recruiting GP practice in Lincolnshire, recruiting 867 participants to 9 different studies. So far in the year April 2023 to April 2024 they have recruited 218 participants to 5 studies.</p>

As part of the NHSAP programme the practice looked at 3 areas to identify innovations and improvements, medication reviews, smoothing patient flow and how the practice can improve the management of the ask my GP system. Improvements made following the NHSAP programme had led to implementation and ongoing changes to the identified areas with 780 hours of clinical time and 572 hours of administrators' time released annually.

Following the completion of the NHSAP programme the provider had continued to utilise the facilitators on a private basis to organise away days for the senior team. This led to a review of governance structures, an agreement for protected time to be restarted for staff to ensure continuous learning and improvement and a review of metrics used within the practice to measure quality and improvements with line managers and the wider staff groups input.

Review of the management of patients living with non-complex mental health issues such as anxiety and depression, led to the development and introduction of a Mental Health Questionnaire. Identified patients completed the annual questionnaire which incorporated nationally recognised scored assessments to allow a patient's condition to be reviewed. These were initially reviewed by a clinical pharmacist who then, dependent of assessment scores either completed the process or arranged a face-to-face appointment with a clinician.

The provider was the only practice in Lincoln and the wider Lincoln area to facilitate the Lincolnshire Community Healthcare Chaplaincy. All patients regardless of faith or belief could book a confidential appointment with a Chaplain. The service was available on a set day each week and offered support to patients as needed.

A Gender Reassignment Policy with an identified GP lead was in place at the practice. Additional training in the subject had been undertaken by 2 of the GPs and further staff training was due to be delivered by an external charity specialising in gender reassignment in October.

Following an audit and review into a pre-cancerous condition suffered by females, the practice had initiated a process for annual follow up to check on any changes that may be concerning. This was above the advised monitoring by the National Institute for Clinical Excellence (NICE) Guidance for the condition.

Following a practice audit regarding patients presenting with skin problems a dedicated skin clinic was introduced. The clinic provided appointments on a Thursday evening and an all-day clinic once a month on a Saturday. Extra clinic slots were made available as increased demand was identified. The clinic was supported by the specialist at the dermatology department in secondary care, who reviewed photographs of any skin lesions and responded with advice on treatment or referral required in a timely way. This had meant patients were able to be treated and reassured quickly in relation to concerns.

Changes were made when staff raised concerns relating to the way the Ask My GP inbox was managed, along with the way patients were prioritised for on the day appointments. This lessened the risk to patients with serious concerns and improved patient safety and care.

The provider had undertaken the Green Impact UNESCO programme designed to support environmentally and socially sustainable practice within organisations.

### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice’s data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice’s data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren’t will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

#### **Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.