Holbeach Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Requires improvement**
Are services responsive to people's needs?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 15 October 2014 as part of our new comprehensive inspection programme. This is the first time that we have inspected this practice.

Our key findings were as follows:

The practice GPs were very committed to their patients and understood their needs in great detail. However, the systems, policies and protocols to support this were in places lacking and confused. The electronic data base needed cleansing to ensure that patent records were correct and provided the right details to ensure that patients received the correct care and treatment according to their needs.

There was little strategic direction or transparent governance within the practice. The practice was concerned that it could not develop or expand until it was provided with a new building that would give space and an environment in which they could effectively lead and manage the day to day delivery of care and treatment for patients.

There were areas of practice where the provider needs to make improvements.

Importantly, the practice must:

- Ensure that there are governance systems and process in place to monitor and maintain the quality of the service provided to patients.
- Ensure that the data quality in patient records both electronic and paper are correct and in line with patients' needs and medical diagnosis.
- Ensure that all risk assessments for the environment, patients and staff welfare and safety are in place and regularly reviewed.
- Ensure that all patients are regularly reviewed and where necessary have a care plan in place.
- Ensure that regular meetings take place for all staff to ensure that changes to guidance and lessons learnt through serious incident reporting and investigation are cascaded to all staff.
- Ensure that there are appropriate protocols in place to support repeat prescribing and nurse led medication reviews

Summary of findings

In addition the provider should

- Improve access to translation services for patients whose first language is not English to ensure confidentiality and an un-biased approach to consultation.
- Ensure that the complaints policy is visible for patients and that learning is cascaded throughout the practice following the investigation of the complaint.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement. The GP in charge of safeguarding was reluctant to use computer alerts when concerns had been expressed about vulnerable individuals who might be at risk. There was no evidence of regular systematic reviews of significant events. Learning from events was limited for all staff as meetings and records of when such learning had taken place was minimal. Risk management was limited with some risk assessments taking place but attention to fire risks had been overlooked for some time. Computer data quality was poor. This reduced the value of the medical records and increased the risk to patients because important medical diagnosis or events might be missed. In addition there were issues with repeat prescribing and reviewing of drugs and clinical conditions.

Are services effective?

Requires improvement

The practice is rated as requires improvement. There was no evidence that the any GP had responsibility for passing on and implementing any changes in best practice or national guidelines through clinical meetings and the development of protocols. Changes to clinical guidelines NICE were implemented on an adhoc basis. The use of templates and alerts was not systematic and the computer system was not being used as effectively as it could be to ensure that best clinical practice was being followed. There was no written evidence provided to support the three audits discussed with the practice. There were very few written protocols for chronic disease review. Learning Disability reviews had only started two weeks before we inspected.

Are services caring?

Good

The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and were involved in care and treatment decisions. Information was available and accessible for those whose first language was English only. The Patient Participation Group (PPG) had tried to address confidentiality in the reception area; posters had been placed in the reception asking patients to stand back. We saw that this was no longer working and privacy was compromised. Some areas of consent were assumed and not obtained explicitly. For example the consent to release a summary care record to care homes.

Summary of findings

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for responsive. Following discussion with the PPG, the practice reviewed its appointment system in August 2012. This led to a vast reduction in missed appointments which was due to the introduction of the duty doctor system. There was little evidence to support that the practice had reviewed its population or had a plan in place to secure improvements. The computer records stated that 168 people were registered whose first language was not English. The practice had never used the translation service and told patients that family or work colleagues could translate. The translation service would provide a reliable and unbiased translation service. Confidentiality was not easily maintained.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for well-led. The practice had a vision and a strategy to deliver this, however not all staff were aware of the vision and their responsibilities in relation to it. The practice had some policies and procedures to govern activity, but some of these were overdue a review. The GPs were clear that they were providing care of a high quality for their patients. However, there was little evidence that they were formally reviewing their processes and performance. The practice depended on the GPs' personal knowledge of the patients and families they had known for years. Unless the information gathered over the years is entered onto the computerised system before the present GPs retire, patients' care could be compromised in the future. Although partners held management meetings every few months, there was no agenda or minutes of these meetings or of planning for the future of the practice.

Summary of findings

The six population groups and what we found

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

Older people

Requires improvement

The practice is rated as requires improvement for the care of older people. Care and treatment of older people did not always reflect current evidence-based practice, and some older people did not have care plans where necessary. Nationally reported data showed that the practice outcomes for conditions commonly found in older people was mixed. When needed, longer appointments and home visits were available for older people and this was acknowledged positively in feedback from patients.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. However not all of these patients had a named GP, personalised care plan or structured annual reviews to check their health and care needs were being met.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. The practice hired rooms from the local health centre that had premises more suitable for suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice had offered online services as well as a full range of health promotion and screening which reflected the

Summary of findings

needs of this age group. Patients told us the online service had been removed and patients were expressing concerns about the availability of appointments. Following on our inspection the practice told us online services were in place.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients whose circumstances may make them vulnerable including homeless people, travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities; however there was no evidence that these had been followed up and they had only commenced in the two weeks prior to our inspection.

Most staff knew how to recognise signs of abuse in vulnerable adults and children. Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the population group of people experiencing poor mental health (including people with dementia). The practice was unable to identify patients experiencing poor mental health or those with dementia. The practice had not worked with multi-disciplinary teams in the case management of people experiencing poor mental health. The practice did not have in place advance care planning for patients with dementia.

Summary of findings

What people who use the service say

Patients' comments varied from positive to negative but some described the staff as being as helpful as possible. Patients who commented on the access to appointments told us that they could not get an urgent appointment and had to wait until the afternoon. Others said that they had been provided with an appointment and seen the nurse and doctor and were now waiting for their prescription.

The practice carried out its own patient surveys annually and had signed up for the Friends and Family Test implemented by NHS England. The Patient Participation Group (PPG) were very active and had brought about change through liaison with the patients. The aim of the PPG is to represent patients' views and to work in partnership with the practice to improve common understanding and obtain patients' views.

We also spoke with five of the seven care homes that were served by the practice. All the care homes told us how they were trying to work in partnership with the practice to reduce hospital admissions. Some spoke of how it was difficult to get appointments. Others told us of how responsive the practice was when called for advice or a visit.

Areas for improvement

Action the service MUST take to improve

- Ensure that there are governance systems and process in place to monitor and maintain the quality of the service provided to patients.
- Ensure that the data quality in patient records both electronic and paper are correct and in line with patients' needs and medical diagnosis.
- Ensure that all risk assessments for the environment, patients and staff welfare and safety are in place and regularly reviewed.
- Ensure that all patients are regularly reviewed and where necessary have a care plan in place.
- Ensure that regular meetings take place for all staff to ensure that changes to guidance and lessons learnt through serious incident reporting and investigation are cascaded to all staff.
- Ensure that there are appropriate protocols in place to support repeat prescribing and nurse led medication reviews

Action the service SHOULD take to improve

- Improve access to translation services for patients whose first language is not English to ensure confidentiality and an un-biased approach to consultation.
- Ensure that the complaints policy is visible for patients and that learning is cascaded throughout the practice following the investigation of complaints.

Holbeach Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, CQC Head of General Practice and an inspection manager.

Background to Holbeach Medical Centre

Holbeach Medical Practice provides primary medical services to patients in Holbeach in Lincolnshire. Car parking is limited and the practice has outgrown its old building.

The practice is staffed by four GP partners of whom one is female. There have only been six GPs at the practice since 1938.The practice employs one practice manager, five nurses, a health care assistant, a phlebotomist, two dispensary staff, a dispensary manager, five receptionist and seven administration staff. The practice provides care and treatment for approximately 7,856 patients. The practice has a proportion of patients from minority ethnic groups and a high proportion of elderly and house bound patients.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out of hours service is provided by Lincolnshire Community Health Services NHS Trust. The practice web site provides clear information as to the opening and closing hours for patients and instructions on who and how to contact the out of hours service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

Detailed findings

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 October 2014. During our visit we spoke with a range of staff including GPs, receptionists, pharmacy dispensers and manager, practice nurse, administrative staff, health care assistant and phlebotomist. We also spoke with patients who used the service.

In addition we carried out telephone interviews with five of the seven care homes that are served by the practice.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice told us that they welcomed the reporting of significant events from any member of staff but no staff other than the doctors could recall submitting a significant event report. We were not shown any evidence of regular systematic reviews of significant events. The doctor advised that that any meeting prompted by a significant event would involve only those directly involved. The GPs only became involved if there was a clinical element. We checked the significant records folder and found that not all significant events had been recorded or reported.

Learning and improvement from safety incidents

The practice did not have a robust system in place for reviewing and analysing significant events. There was no dedicated time or meetings for all staff to discuss the learning from significant events. There was no evidence that appropriate learning had taken place or that the findings were disseminated to relevant staff.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system she used to manage and monitor them. We tracked three incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. For example an incorrectly dispensed medication led to a bar coded system linked to Systm One to eliminate the risk. However, there was no evidence that any learning from this had been cascaded to staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of the medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible to all GPs, included the contact name and telephone number for the safeguarding team at NHS England, Lincoln.

The practice had dedicated GPs appointed as leads in safeguarding vulnerable adults and children and would refer to the safeguarding alerts on patient records. All the GPs had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. However, the GP charged with the lead role for safeguarding was reluctant to use the computer alerts when concerns had been expressed about vulnerable individuals who might be at risk. Because of the record sharing facility of SystmOne, he could not control who had sight of the clinical records and so for medical-legal reasons only factual information was recorded. The practice received on going help and support to address the practice accuracy with patient records from the Data Quality Team.

A chaperone policy was in place but not clearly visible to patients in the waiting room or in consulting rooms. We saw records that stated chaperone training was to take place. Staff we spoke with understood the chaperone policy.

Patient records were kept in an electronic system called SystmOne, which collated all communications about the patient, including scanned copies of communications from hospitals. However, the practice had identified problems with the system since changing from Emis LV to System One in 2012. Emis LV was a type of electronic data base for recording patient consultations. We were told that the system had corrupted some of the data which meant that some patients had been given the wrong coding. For example, some men had been identified as being pregnant. In addition the process lost computer templates and computer protocols that helped chronic disease management. The practice had sought help from the CCG to try and resolve the matter but concerns still remained. Records we looked at showed they had not been reviewed. For example a patient had been coded as being pregnant for a number of years and no check had been carried out for thyroid function. Audits had not been carried out to assess the completeness and accuracy of records.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring medicines were kept at the required temperatures. The action to take in the event of a potential failure was described. This was being followed by the practice staff.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with relevant regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

We discussed repeat prescribing with the dispensing manager and staff. They told us that each drug on patients' repeat prescription counterfoil had a review date. However, this was described by the dispensers as not always correct. Asthmatic patients who were requesting excessive amounts of bronchodilator inhalers were seen by a GP to review the reasons why. Elderly patients, particularly those on multiple medications were reviewed annually in the nurse run clinics. No evidence of a protocol or details of the training received by the nurses to undertake these reviews was provided.

There was no proactive system in place for the management of high risk medicines such as regular monitoring in line with national guidance. Clinical records we reviewed further showed the lack of a proactive system. For example a patient with an underactive thyroid had no recall date for repeat blood tests. One patient had been issued with warfarin even though the records contained no (INR) results. This is a blood test required for patients who are taking warfarin. It tests how long the patients' blood takes to clot when bleeding occurs. The records did not reflect a relationship between issuing warfarin and the need for a blood test showing an appropriate INR. Lithium monitoring – the practice deals with 3 Mental Health Trusts (MHT) which have different protocols for monitoring Lithium treatment. The practice had assumed that the MHT would monitor blood levels and advise of the dosage. The practice continued to provide prescriptions for Lithium without a system for reviewing whether the dosage was correct. One patient's record was flagged with the advice to review bloods every three months. The last medication review was five months ago and the next medication review was seven months away.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard. Access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual, quantities, doses, formulations or strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We observed this process was working in practice.

We saw records showing all members of staff involved in the dispensing process had received appropriate training and had checks of their competence signed by the lead GP.

The practice had established a service for people to pick up their dispensed prescriptions at two locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure people collecting medicines from these locations were given all the relevant information they required.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and annual updates. We saw evidence the lead had carried out an audit in May

2014 and that any improvements identified for action were completed within the time stated. However the practice meeting minutes did not show that infection control was discussed or that there were actions required from audits.

An infection control policy and supporting procedures were available on System One and in hard copy for staff to refer to. These enabled staff to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these in order to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the water which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. There were also arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. However, there were some policies that were not in place and we found three different fire policies. Regular risk assessments were not being undertaken for all areas of the practice. The practice's own policy said that they should be undertaken every three to four months. However some had only been completed once and were dated 13 October 2014. In addition there was not one for the loft in which the practice had stored old patient files. The storage of the files was a potential fire hazard and the practice manager agreed to address this matter with the fire authority immediately. The fire risk and environmental assessments had not been finished. Testing for legionella and electrical equipment had been completed.

There was not a comprehensive and complete risk log to demonstrate that each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

The practice did not routinely hold stocks of medicines for the treatment of medical emergencies. However, the practice did store adrenaline, a medicine used to treat severe allergic reactions. The local ambulance service had given a commitment to arrive within seven minutes of any

Requires improvement

Are services safe?

called emergency. In addition due to the in-depth and longstanding knowledge of their patients the GPs knew when to carry extra things for their home visits such as anti-emetic injections if the patient was vomiting.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment was in place that included actions required to maintain fire safety. However, not all of these actions had been addressed. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken but there was currently no fire warden appointed.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches.

The practice nurse told us they led in specialist clinical areas such as diabetes, heart disease and asthma. We were not shown any written protocols for the chronic disease reviews and nor did we see these on the System One templates for chronic disease. We saw that reviews of patients with a learning disability had only begun two weeks before our inspection. Reviews of patients with a learning disability should take place at least once a year.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need, and that age, sex or race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts, and medicines management. Practice Nurses used templates for every aspect of their clinical work. However there was no systematic approach. Alerts were documented and in place for safeguarding, allergies and adverse reactions. The computer system was not being used as effectively as it could be to ensure that best clinical practice was being followed.

We discussed three audits with the practice GP but were not provided with any written evidence. The three audits were for urinary tract infections, two week cancer referrals and atrial fibrillation. The results of the audits were not systematically shared with the other GPs and there was no clear evidence of completed clinical audit cycles.

The practice did not hold regular meetings to discuss QOF and was in the worse than average quartile for QOF. In addition the practice was also in the lowest quartile for diabetic patients that should have had a flu vaccination.

Effective staffing

there was a mixture of medical, nursing, managerial and administrative staff at the practice. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

The practice relied on the NHS appraisal system using external GP appraisers for partners and salaried doctors. These appraisals were incorporated into the GMC (General Medical Council) revalidation process. The practice had no internal appraisal system in place for the partners.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, on the administration of vaccines. Those with extended roles such as COPD, diabetes and coronary heart disease, were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately. Admission Avoidance meetings were documented with agenda and minutes in place.

The practice was part of the Boston Locality Care Home Project. This project had been set up to support better communication and improve hospital avoidance. The practice manager led the project for the practice and had been meeting with seven care homes with nursing for some time. Initiatives had been developed such as a 'quick glance' summary print out from medical records.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice told us that they held admission avoidance meetings. However, these were not documented and it was not clear who attended them.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's (OOH) provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. All information from OOH and 111 services was faxed to the practice and circulated via the practice's paper based document management system. Do not resuscitate (DNAR) forms were left with the patient and recorded on System One. Details of DNAR forms did not appear to be passed to secondary care teams or to the ambulance service.

The practice had agreed to use the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record known as SystmOne was used by all staff to coordinate, document and manage patients' care. However, it was clear from speaking to staff and reviewing the system that the system was not as effective as it could be. We were told that since changing from Emis (another electronic system) the patient records were not always an accurate reflection of patient's true medical condition. For example, some male patients were said to be pregnant on the system. The practice was working with the CCG to rectify this data issue.

In addition, there were concerns about the storage of patients' records in the loft (a room accessed by a small door from the top of the stairs next to the administration office). These records were stored in cardboard boxes before they were summarised and added into SystmOne. No risk assessment had been completed for the storage of these records; in particular no fire risk assessment had been completed.

Consent to care and treatment

Some staff had received Mental Capacity Act 2005 training and there were plans to cascade the training to the remaining staff as soon as possible.

We were informed that patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. However, there were very few care plans in place and the learning disability reviews had only just begun. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25.

The practice also offered NHS Health Checks to all its patients aged 40-74.

There was a policy to telephone patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named nurse responsible for following-up patients who did not attend screening. Similar mechanism of following up patients were in place for patients who did not attend other screening appointments such as for breast and bowel cancer.

The practice offered a full range of immunisations for children. The practice also offered travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was above average for the CCG. There was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's Patient Participation Group. Data from the national patient survey showed the practice was rated 'among the best' for patients rating the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses. Respondents also said that the GPs were good at listening to them and gave them enough time.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it did not always enable confidentiality to be maintained. People we spoke with from the PPG (Patient Participation Group) said this system was not always effective and that more needed to be done to maintain confidentiality.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Since September 2014 patients over 75 years had been invited for their over 75 year check or seen within their chronic diseases assessment consultation, and provided with a care plan. All care homes had up to date care plans for patients, and the practice manager had visited all the care homes working with the home care project with the Boston Clinical Commissioning Group (CCG).

Staff told us that translation services were available for patients who did not have English as a first language. The practice's computer records showed that 168 patients did not have English as a first language. However, the waiting room check in screen was in English only. The practice had never used Language Line. Staff told us that patients' family or work colleagues could translate if required. Language Line would give a reliable un-biased confidential translation service that can be used easily in line with consultation.

Staff were very committed to acting in the best interests of the patients. We observed that receptionists and dispensers demonstrated a very caring and professional manner when dealing with patients face to face.

Patient/carer support to cope emotionally with care and treatment

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. GP's also visited their patients in hospital. Patients we spoke to who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood as most GPs at the practice had been at the practice for many years. Many of the patients had been on the practice list for most of their life. We were told that GPs carried a large amount of information about patients and their families in their head. This information was not always reflected in the computerised medical records. The long relationship between the GPs and their patients aided their traditional approach to personal care for their patients.

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

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). Patients had found it difficult to obtain an appointment. The appointments system was reviewed as was how the practice managed those patients that did not attended for their appointment(DNAs). This review led to a large reduction in DNAs which reduced from 250 to 20 per month.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. This has worked especially well with the local seven care homes project.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to online and telephone translation services. However staff spoken to advised that they had not been used as the practice preferred to use family and colleagues.

The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

The premises and services had been adapted to meet the needs of people with disabilities. A ramp had been provided to the front of the building to allow for wheel chair access. Hearing loop facilities were available. Hearing dogs were welcomed and guide dogs to be invited in from 2015 to raise awareness and to support patients.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation.

Access to the service

There had been very little turnover of staff for many years which enabled good continuity of care. There was also good accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them such as those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to seven local care homes on a specific day each week, by a named GP and to those house bound patients who needed one. In addition, the practice worked with the Boston Locality Care Home Project to provide a buddy for any immediate problems. The buddy an identified person in the practice that the care home speaks to about concerns and problems. All the homes had a dedicated telephone number to use and received a telephone call response within 15 minutes of the initial call.

The practice was open for appointments weekdays from 9am to 11am and 3pm to 5pm. The practice opened 8-9am and 5-6.30pm for patient's enquiries and administrative purposes The dispensary was open weekdays from 9am to 6pm. .

Information was available to patients about appointments on the practice website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Patients held mixed views about the appointments system. Some told us that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. However others were less satisfied with the system as the ability to book appointments on line had been stopped and patients could only call at 8am or 1pm to make an appointment.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Some patient reviews on NHS Choices (total of 14) were positive about all aspects of the practice. Most were anonymous, with nine being negative about difficulties in obtaining an appointment. The practice had responded by introducing the Book on the Day (BOD) appointments system.

Other comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day they contacted the practice.

The practice's appointment system was altered in August 2013 following a discussion with the PPG and was considered by the practice to be working well providing a variety of appointment types. These included ten minute appointments that were bookable up to month ahead, book on the day (kept for issues that could not wait for routine appointments). A duty doctor was available every day to see patients either in the surgery or at home. There were no audits seen of the appointments system or any monitoring of trends.

Listening and learning from concerns and complaints

The practice informed us that it had a system in place for handling complaints and concerns. There was no information about the complaints procedure for patients visible in the waiting room.. However, we were told that the complaints policy and procedures were in line with guidance and contractual obligations for GPs in England. There was detailed information about the practice's complaints policy on their web site. The web site also signposted patients to an independent advocate who could help them with their complaint if necessary. There was a designated responsible person who handled all complaints in the practice and the receptionist knew about the complaints procedure.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We could not look at historical complaints as all complaints received and recorded had been lost as a result of storm and flood damage (the records were kept in the loft).

We reviewed the complaints policy and recent complaints. The practice had received five complaints in 2014, of which three were about appointments. There had been no evaluation of the issues in relation to the complaints and no evidence of any learning that had taken place throughout the practice.

Are services well-led?

Requires improvement

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

Our findings

Vision and Strategy

The practice had a strong commitment to providing personal care to their patients through their personal knowledge of patients and families they had known for years. There was no clear vision or documented business plan/strategy for the practice.

Staff at the practice told us if they had a new building they could not develop or expand on any of the services that they currently provided.

There was limited room to develop the practice in line with the expanding needs of the patients. For example the practice would like to expand but was unable to accommodate another GP and a practice nurse due to the lack of consulting rooms. The practice manager often had to move out of her room to accommodate the administration staff. To compensate for this, the practice hired two rooms four days a week from Holbeach Health Centre across the road. The practice had produced numerous plans for new premises but there were business plans and were not supported by the Lincolnshire Clinical Commissioning Groups (CCG) and other stakeholders.

was still no confirmed premise or date when this could happen.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. However, when we reviewed these they were muddled, fragmented and lacked review dates.

Regular informal partner meetings were held with the practice manager to review day to day issues. The practice also held meetings every few months to discuss management issues. However, there were limited records of these meetings or any arising action points.

Full staff meetings were only held infrequently. We saw records to suggest that there had only been four meetings since March 2012. The agenda's and actions did not include actions taken in response to review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We did see a policy for repeat prescription and medication reviews that was held on SystmOne.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a system used to monitor the quality of services in GP practices. QOF consisted of groups of indicators against which practices score points according to their level of achievement. The QOF data for this practice showed it was performing in line with most of the national standards. However, this was not the case for multidisciplinary meetings that should in line with best practice be held every three months.

We were informed that the practice had completed a number of clinical audits, for example urinary tract infections, two week cancer referral and atrial fibrillation. However, we were not provided with any written evidence of this, only that verbal feedback was provided in the informal daily meetings. None of the learning from these audits was systematically fed back to the rest of the practice staff.

The practice's arrangements for identifying, recording and managing risks were not consistent or systematic. Some of risk assessments had been completed but there were gaps for example a full fire risk assessment f the total environment had not been completed. There were also three different fire risk assessments and none of these included a fire risk assessment for the loft where some patient records and other documents were stored.

Leadership, openness and transparency

There was a lead nurse for infection control and the senior partner was the lead for safeguarding. Staff told us that they felt valued, well supported and knew who to go to in the practice with any concerns. However, the lack of systematic monitoring systems in some areas and poor record keeping did not provide a clear accountable leadership for the practice

Team meetings were not held regularly and the recording of meetings was limited. The practice said that they found it hard to hold meetings as they had very little space in the building. All space available was needed for consultation and or treatment.

Practice seeks and acts on feedback from users, public and staff

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG contained representatives from various population groups who spoke well of the commitment of the practice to their patients.

Are services well-led?

Requires improvement

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

The PPG met regularly and had influenced change from patient feedback. For example, we saw as a result of this the practice had some time ago reviewed it appointments system.

Management lead through learning & improvement

Some training and development had taken place but this was not systematic. Records of training were not always maintained or monitored through practice meetings.

The practice had completed reviews of significant events and other incidents. However, there was not a system for systematically sharing these with the staff or learning from these issues.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to a, regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this art of the regulations; and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services 9 (1) the registered person must take proper steps to ensure that each service user is protected against the risk of receiving care or treatment that is inappropriate or unsafe, by means of (a)the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and , where appropriate, treatment in such a way as to (i) meet the service users individual needs (ii) ensure the welfare and safety of the service user.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

The registered person must ensure that service users are protected against the risks of unsafe or appropriate care and treatment arising from a lack of proper information about them by means of the maintenance of

a, An accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user

(2) the registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are

(a) kept securely and can be located promptly when required.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.