Boultham Park Medical Practice

Quality Report

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Date of inspection visit: 07 May 2014
Date of publication: 10/09/2014

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.

Summary of findings

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Overall summary

The practice was providing safe care. The practice learned from incidents, complaints and patient feedback and took action to improve to ensure safe patient care.

The care and treatment provided to patients was effective. There was evidence of robust clinical audits taking place to ensure positive clinical outcomes for patients.

The service was caring with all staff displaying an exemplary attitude towards patients and their care and treatment.

The service was responsive to patients' needs. Complaints were investigated and responded to and lessons were learned to improve practice.

The service was well-led in most respects. There were visible and responsive leaders and a culture of openness where all staff felt valued, respected, able to express their views and be heard. All practice staff had shared vision and values and there was an expectation of high standards of patient care.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was providing safe care.

The practice learned from incidents, complaints and patient feedback and took action to improve to ensure safe patient care. The arrangements in place for emergency situations were clear and ensured patients were safe and their health was protected.

Patients who were in vulnerable situations were safeguarded by knowledgeable and trained staff underpinned by effective systems for sharing information and highlighting risk.

The systems in place for repeat prescriptions were robust and ensured patients received the correct medicine at the right dose and that medicines prescribed continued to be safe and appropriate for each individual patient.

Are services effective?

The care and treatment being provided to patients was effective.

The assessment, monitoring and treatment provided to patients with long- term (chronic) conditions followed current research based best practice guidelines.

The doctors and nurses working at the practice had a clear insight into the health needs of the patient population and the challenges these presented to both the patient and the practice in maintaining their health and wellbeing. There was evidence of robust clinical audits taking place to ensure positive clinical outcomes for patients.

Patients were referred to specialists where necessary and staff at the practice ensured care was co-ordinated and there was clear communication between professionals and the patient when they had complex needs or health conditions.

Are services caring?

The service was caring with all staff displaying an exemplary attitude towards patients and their care and treatment. We saw examples of GPs going the extra mile to advocate on behalf of their vulnerable patients with other agencies.

The feedback from patients and staff in care homes was (with one exception) positive. Patients told us they were happy with the quality of the care and treatment they received at the practice.

Summary of findings

Are services responsive to people's needs?

The service was responsive to patients' needs. The patient participation group (PPG) told us the staff at the practice listened to them and valued their work.

We saw the results of the recent patient survey and these were very positive in all areas indicating high levels of patient satisfaction with the service.

Patients had the choice of male and female GPs and the premises were accessible to patients with disabilities. Information about the service was displayed and available on the website including information targeted at specific patient groups. The practice provided on line services, text reminder services and provided an extensive range of information for patients on their website and in the practice itself.

Complaints were investigated and responded to and lessons were learned to improve practice.

Are services well-led?

The service was well-led in most respects. There were visible and responsive leaders and a culture of openness where all staff felt valued, respected, able to express their views and be heard. All practice staff had shared vision and values and there was an expectation of high standards of patient care.

The practice manager provided strong leadership; but the roles and responsibilities of different staff members needed clarifying to ensure the systems in place were effective and minimised the risks to patients, staff and others.

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

Patients over the age of 75 could have a health check every year.

The doctors and nurses told us the practice had a higher number of older patients who were attending the practice or needing home visits more frequently. The nurse practitioner told us they saw a number of older patients who did not have any contact with other agencies or professionals and provided clinical care as well as a listening ear.

The practice worked closely with the palliative care team as patients approached the end of their life and we saw records which demonstrated collaborative working took place. Staff at the practice told us they worked to the gold standards framework (GSF) goals.

We spoke with the managers of four care homes (for older people or younger adults with disabilities) whose patients were registered at the practice and they told us the practice staff were very responsive to their patients' needs. They told us the GPs would review people with complex needs or care plans and would support care home staff in difficult situations.

The practice was accessible for all patients with parking for people with disabilities; level access adapted toilets and a vertical lift.

People with long-term conditions

Boultham Medical Centre was highlighted as being an outlier in respect of the number of patients who had a diagnosis of chronic obstructive pulmonary disease (COPD - a long term respiratory disease.) An outlier means that the numbers of patients with this condition is high when compared with other practices. We identified that the high incidence was due to a high incidence of COPD locally prompting need for specialist nurse who was effective at diagnosis and treatment. There were systems in place to ensure patients were regularly monitored and provided with extensive information about the condition along with opportunities to improve their health through education on diet, exercise and smoking cessation.

The GPs undertook clinical audits to assess how they were performing when compared with best practice guidance and clinical standards. The audits were comprehensive and demonstrated an ongoing commitment to learning and improving.

Summary of findings

Mothers, babies, children and young people

The practice had a separate waiting room available for children, young people and families if they chose to use it. The room had a notice board with information specifically targeted at this group of patients, such as information about family centres, breastfeeding and information directed at teenagers attending the health centre.

We observed there was a robust system in place at the practice to flag child protection concerns which ensured all practice staff were alerted to the potential risks to each child who may be vulnerable to harm or abuse. This flagging system was applied to the patient records of all family members to ensure crucial information about early detection was not missed. The senior partner told us the out of hours service was also able to access the contemporary patient records from the practice which meant they were also alerted to any information about the risks of harm or abuse for vulnerable children.

The practice staff were responsive to mothers, babies and young children and had made changes to the way they worked to accommodate their needs. For example, the timeslots for the first time a parent attended baby clinic had been extended from 10 to 15 minutes to make sure all of the necessary tasks could be undertaken and to avoid rushing new parents. We spoke with a patient who was attending with their child who had brought the child to see a specific doctor as they felt the GP had a kind manner with children and young people and was reassuring to them and their child.

The working-age population and those recently retired

People over the age of 45 were offered well man or well woman checks to look for early signs of life long illnesses, or worsening physical or mental health. Some patients told us these routine appointments had led to them being diagnosed early with long term health conditions and they had been able to learn about how they could improve their own health.

The GPs and other practice staff were aware of the challenges the appointment system presented for working age patients and as a result had introduced a number of initiatives to try and improve access for these patients including telephone triage, developing an on call system and arranging for extended opening hours offering pre-bookable appointments one evening a week or on a Saturday morning. The working age patients we spoke with appreciated these developments and told us they could usually get an appointment when they needed one.

Summary of findings

There was a range of information available to working patients or those who had recently retired in the practice and on the practice website. The website provided information about self-management of minor illness for working age patients to avoid the need for them to attend the practice if this were not needed.

People in vulnerable circumstances who may have poor access to primary care

The GPs told us that some of their patient population had a dependence on drugs; we looked carefully at the management of medicines to make sure these systems were safe and patients were protected from harm. There were no patterns of untoward incidents involving medicines. This system was especially robust in respect of controlled drugs (CDs). Controlled drugs are medicines which are subject to extra controls as there is a potential for them to be misused or obtained illegally causing potential harm.

The doctors and nurses working at the practice had a clear insight into the health needs of the patient population and the challenges these presented to both the patient and the practice in maintaining their health wellbeing. Some patients at the practice lived in deprived circumstances and had drug or alcohol dependency and the GPs had a clear understanding of the local organisations available to provide support, advice and treatment for patients with these needs. We saw there was information available in the waiting area about needle exchange services. This ensured patients who injected drugs were signposted to places where they could obtain clean needles; reducing the risk of acquiring infections which presented significant risks to their health.

The majority of patients registered at the practice were white, British. We spoke with some patients whose first language was not English and they told us they usually used a family member to interpret for them. The family member was a young person and we were concerned it may not always be appropriate to involve them, especially if the doctor had to break bad news. We asked staff about access to the interpreting service and they were unsure how to access this due to changes within local healthcare funding. We provided some information to the practice about accessing interpreters as needed to ensure clear communication could take place between practice staff and patients needing translation services.

Home visits were available and were undertaken by both doctors and the nurse practitioner; these visits were reserved for people with

disabilities or those who could not or would not leave their house to attend the practice due to illness or disability. This resulted in these appointments being kept for those who were most vulnerable and in need of the service.

People experiencing poor mental health

The Lincolnshire area health profile highlighted that hospital stays caused by self-harm were significantly higher than the England average. For this reason we looked at how the practice identified and responded to patients with depressive illnesses. The practice staff had an excellent knowledge, understanding of and commitment to this vulnerable group of patients. We saw evidence to show GPs advocated strongly for their patients with other organisations to ensure that those experiencing mental ill health were not placed under undue pressure which may increase feelings of despair or hopelessness and may lead to an increased likelihood of self- harm taking place.

GPs told us they made use of information provided by patients about (for example) stress and information about their personal circumstances. They told us they also used recognised assessment tools to monitor the severity of depression and the patient's response to treatment. They told us this enabled them to assess and respond appropriately to risk. Records we saw confirmed that there was careful monitoring of patients' mental health, and referrals were made for specialist support as appropriate to ensure patients received the help, support and treatment they needed to maintain their health and safety. Analysis of adverse events demonstrated that there was a considered and robust approach towards looking at clinical practice, missed opportunities for engagement and learning lessons to improve practice and ensure risks were monitored.

Staff at the practice told us there were meetings with other professionals and agencies where patients with complex needs were discussed, information was shared and care and treatment planned and co-ordinated to ensure an integrated approach. This was confirmed by comments from managers in care homes, patient comments and by records of meetings.

Summary of findings

What people who use the service say

Out of the 20 patients we spoke with or received comments from, all but one expressed high levels of satisfaction with the service provided at the practice, stating they felt respected, listened to and could access a clinician in an emergency situation.

Patients told us they had received information about their illness or disability in various ways, including in writing and verbally. All of the patients we spoke with told us the practice staff answered any queries they may have and several told us they had never left the practice with any unanswered questions.

A patient survey was undertaken in January 2014 and the results were published on the practice website. The results demonstrated high levels of patient satisfaction.

We spoke with four care homes who had patients registered with the practice (providing care to younger adults or older people) and they were all very complimentary about the service provided. They told us GPs always visited on request and they told us the practice staff worked well with the care home in complex or difficult situations and made referrals for specialist assessment promptly to make sure patients received expert assessment and treatment.

Areas for improvement

Action the service COULD take to improve

- The provider could take steps to ensure that recruitment policy checklists were fully completed in every case thereby ensuring they had full and complete information on every member of staff to protect patients from those who may not be suitable to work with them.
- The provider could take steps to ensure the protocols and policies in place were reflective of practice.
- The provider could take steps to make the clinical auditing cycle a collaborative system involving the whole practice team to promote and encourage shared learning.
- The provider could ensure there was more clarity about the roles and responsibilities of others in the practice to ensure consistent oversight of systems, overall practice risks and to ensure effective quality management.

Good practice

Our inspection team highlighted the following areas of outstanding practice:

- The practice had a separate waiting room available for children, young people and families if they chose to use it. The room had a notice board with information specifically targeted at this group of patients, such as information about family centres, breastfeeding and information directed at teenagers attending the health centre.
- The systems in place for repeat prescriptions were very robust and the systems in place ensured GPs could make sure that patients received the correct medicine at the right dose and that medicines prescribed continued to be safe and appropriate for each individual patient. The arrangements in place to ensure the safety of controlled drugs were safe and effective and as far as possible ensured that such medicines were given to the patient they were intended for.
- The system in place for diagnosing patients with COPD was robust. The practice employed a nurse who had specialist expertise in respiratory disease and patients were given information and had an active management plan to improve the health of and educate patients in the management of this long term health condition.
- The GPs advocated strongly with other organisations on behalf of patients experiencing mental ill health who were struggling with areas of stress and pressure in their lives. They went the extra mile to ensure that those experiencing mental ill health were not placed

under undue pressure which may increase feelings of despair or hopelessness and may lead to an increased likelihood of self- harm taking place. This was a consistent and considered response from all of the GPs in the practice.

Boultham Park Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector and a GP and the team included another CQC inspector and a practice manager.

Background to Boultham Park Medical Practice

Boultham Park Medical Centre is a single practice, with no branch surgeries. It provides general practitioner services to a patient population of 9,300; there are five GP partners. Boultham Medical Centre is a training practice, providing work placements for doctors in training.

The practice serves a mixed age population, a significant proportion of whom are older people. Some patients registered with the practice live in deprived circumstances and experience mental ill health or have alcohol and/or drug dependencies. The vast majority of patients in the practice are white British with the largest minority ethnic patient group served being Eastern European.

This is the first time this practice has been inspected.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting we reviewed a range of information we hold about the service and this highlighted that the practice had a very high number of patients with chronic obstructive pulmonary disease (COPD). We looked at the reasons for this high incidence as part of this inspection. We asked other organisations to share what they knew about the service and the feedback received was positive. We also attended a listening event about a local NHS Trust we were inspecting. The information available on NHS Choices was positive and the three comments and ratings supplied by patients were complimentary about the practice.

Detailed findings

We carried out an announced visit on 07 May 2014. During our visit we spoke with sixteen patients and received comment cards from a further four patients. With the exception of one patient, all the patients we spoke with were very happy about the quality of care and treatment they were receiving. We considered the concerns raised by this patient as part of our inspection. We also spoke with the staff working at four care homes covered by the practice; their comments about the service were very positive and their only identified area for improvement was in communicating test results.

We spoke with the practice manager; all five GPs, three nurses, the phlebotomist and all of the reception and administrative staff to help us identify whether the service was safe, effective, caring, responsive and well-led. We observed how people were being responded to and talked with carers and/or family members as well as six members of the patient participation group (PPG). The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Are services safe?

Summary of findings

The practice was providing safe care.

The practice learned from incidents, complaints and patient feedback and took action to improve to ensure safe patient care. The arrangements in place for emergency situations were clear and ensured patients were safe and their health was protected.

Patients who were in vulnerable situations were safeguarded by knowledgeable and trained staff underpinned by effective systems for sharing information and highlighting risk.

The systems in place for repeat prescriptions were robust and ensured patients received the correct medicine at the right dose and that medicines prescribed continued to be safe and appropriate for each individual patient.

Our findings

Safe patient care

There was a policy in place indicating what types of incidents would be recorded as significant events and how these would be analysed. Practice staff told us that anyone in the practice could report a significant event, and they told us all significant events were subject to a process of root cause analysis and discussed as a practice to ensure learning took place. A root cause analysis process involved a member of staff at the practice analysing the reasons the event occurred; any actions taken by practice staff and what changes needed to happen to prevent such an incident recurring. This learning was discussed and shared with staff and changes were made to practice when things had gone wrong.

There had been nine significant events in the past year. An analysis of these records demonstrated there were no patterns to indicate there were any recurring themes of incidents at the practice which may suggest a failure to learn and adapt practice when things went wrong. The system was robust and ensured learning took place and changes were made following significant events to ensure patient safety was maintained.

Learning from incidents

We looked at the root cause analysis documents and found them to be a robust review of significant events. This was particularly the case where issues of clinical practice were being analysed which had affected patient safety or potentially had this impact, such as situations where patients had ended their own life or where there had been concerns about prescribing. The GPs all told us the learning from significant events was used as part of the appraisal system in place at the practice to ensure learning was embedded in future practice.

We saw the practice staff took responsibility for raising concerns about how other agencies had responded in some situations to ensure patient safety was paramount and learning took place within other organisations. Learning and future action points were clearly highlighted within the root cause analysis documents and records and comments we received indicated these were fully discussed with staff. This indicated the changes to practice had ensured patients received safe care and treatment. The practice manager and partners told us that the

outcomes of significant events analysis were shared with the Clinical Commissioning Group (CCG) so they could assure themselves that the same issue would not happen again and patients were safe.

We observed patient safety alert notices on display in the staff room about ID thefts and about hazardous substances so staff were alerted to these concerns and could take action to protect themselves and patients against risks to their safety. The practice manager told us these were routinely placed on the staff notice board and also brought to the attention of staff so they could read them and take any necessary action. Patient safety alerts are sent to the practice by the Medicines and Healthcare Products Regulatory Agency (MHRA), the National Patient Safety Agency (NPSA) or the Department of Health. These notices cover a wide range of topics and help providers learn lessons from each other and ensure they are aware of risks to the safety of patients so they can take action to minimise these.

Safeguarding

There were clear policies in place in respect of child protection and adult safeguarding which would enable staff to understand what actions they should take if they witnessed abuse or had a suspicion that this may be taking place. The staff we spoke with had all received child protection and safeguarding training and demonstrated their knowledge and understanding about what to do in situations where children or adults were in vulnerable situations and at risk of harm or abuse to ensure action was taken to protect them.

GPs told us that they were often unable to attend safeguarding and child protection strategy meetings due to short notice, but they confirmed they provided written information on request to enable children and adults who were vulnerable to harm or abuse to be protected. They confirmed they also ensured they received the minutes and outcomes from these meetings to ensure they could be vigilant and take action to protect vulnerable children or adults. The senior partner told us the out of hours service was also able to access the contemporary patient records from the practice which meant they were also alerted to any information about the risks of harm or abuse for vulnerable adults or children. The system in place ensured crucial information was shared between services to enable appropriate protection of vulnerable children or adults.

We observed there was a robust system in place at the practice to flag safeguarding or child protection concerns which ensured all practice staff were alerted to the potential risks to each patient who may be vulnerable to harm or abuse. This flagging system was applied to the patient records of all family members to ensure crucial information about early detection was not missed. The senior partner could demonstrate how details of safeguarding and child protection concerns could be retrieved easily and all of the staff we spoke with were familiar with the system in place. The system in place enabled practice staff to be alerted to the risks to vulnerable children and adults and ensured they had the knowledge and information they needed to ensure these patients were safeguarded from harm or abuse.

Monitoring safety and responding to risk

The GPs told us they had a pro-active approach to monitoring safety and responding to risk which involved all staff, patients and the patient participation group (PPG). Practice staff and PPG members confirmed that they felt confident to raise any issues concerning patient safety and stated these would be followed up.

The Lincolnshire area health profile highlighted that hospital stays caused by self-harm were significantly higher than the England average. For this reason we looked at how the practice identified and responded to patients with depressive illnesses.

In assessing and responding to risk GPs told us they made use of information provided by patients about (for example) stress and information about their personal circumstances. They told us they also used recognised assessment tools to monitor the severity of depression and the patient's response to treatment. They told us this enabled them to assess and respond appropriately to risk. Records we saw confirmed that there was careful monitoring of patients' mental health, and referrals were made for specialist support as appropriate to ensure patients were received the help, support and treatment they needed to maintain their health and safety. Analysis of adverse events demonstrated that there was a considered and robust approach towards looking at clinical practice, missed opportunities for engagement and learning lessons to improve practice and ensure risks were monitored.

Boultham Medical Centre was highlighted as being an outlier in respect of the number of patients who had a diagnosis of chronic obstructive pulmonary disease (a long

term respiratory disease.) An outlier means that the numbers of patients with this condition is high when compared with other practices nationally. We looked at the reasons for this very high incidence and were assured that the high rate of diagnosis was because there were clear systems in place to diagnose patients with this condition, including employing a member of staff who was a former respiratory nurse and very pro-active at ensuring patients received an early diagnosis and treatment. This was confirmed by the records we saw.

Medicines management

The GPs told us that some of their patient population had a dependence on drugs, we looked carefully at the management of medicines to make sure these systems were safe and patients were protected from harm. There were no patterns of untoward incidents involving medicines.

We found there were safe systems in place for repeat prescribing at the practice. Patients we spoke with told us the system was easy to use and those receiving repeat prescriptions told us they felt the system worked well and was very efficient and meant they did not run out of prescribed medicines. This was confirmed by our observation of the system in practice and from comments from staff. Requests were dealt with as they came in. There were additional safety checks in place for repeat prescriptions meaning every prescription had an action sheet attached which asked the GP or nurse prescriber for a decision as to whether to issue the medicine, ask for blood tests or ask the patient in for a medication review. This system meant it was unlikely that repeat prescriptions would be issued for inappropriately long periods of time without being reviewed.

This system was especially robust in respect of controlled drugs (CDs). Controlled drugs are medicines which are subject to extra controls as there is a potential for them to be misused or obtained illegally causing potential harm. Requests for repeat prescriptions of CDs were passed to a GP for an authorising signature before being given to the patient in all cases. The practice staff had put further safeguards in place by asking the patient to state on a written form who would collect the CDs (including whether someone would do this on their behalf) and what their relationship to the patient was. The prescription was only handed to the person authorised to collect this on production of photographic ID and they and the receptionist signed to confirm receipt. The system ensured patients were more likely to receive the medicines prescribed for them and there was less likelihood of CDs being collected by a person who was not authorised to do so.

We looked at the GP's on call bags and observed that GPs tried to keep the number of medicines held in the bag to a minimum. We saw a list of the medicines in each bag along with the expiry date. The GPs and practice manager confirmed that he sent out reminders to GPs when expiry dates were approaching to make sure medicines given to patients were safe for use. We checked the vaccines held at the practice and these were all securely stored in accordance with the manufacturer's directions and were checked daily to make sure they were in date and therefore safe to use. There were also regular checks on oxygen and there was clear signage indicating where oxygen was stored so the fire and rescue service could take all necessary precautions in the event of a fire.

Cleanliness and infection control

All of the patients we spoke with told us the practice was clean and they told us practice staff washed their hands and used personal protective equipment (PPE) for examinations. There were clear infection control policies in use at the practice and a named lead for cleanliness and infection control who undertook random hand washing audits to ensure good hand hygiene practices were observed to prevent infections passing between staff and patients.

Cleaning was undertaken by staff employed by the practice and the practice was clean, tidy and all clinical areas were safe for use. Practice staff told us there were good stocks of PPE and we observed this to be the case.

Staffing and recruitment

There were clear policies in place describing how the practice ensured the recruitment of staff was safe. We saw the practice manager had both a checklist and a flow chart to help check safe recruitment policies were followed at all times.

We looked at a random selection of staff files to make sure this system worked in practice to ensure that patients were protected against the risks of staff who may be unsuitable to work with vulnerable adults or children. We found in the majority of cases that staff files contained the necessary information and checks. In one case we found a member of

Are services safe?

staff had a key check missing, and we brought this to the attention of the practice manager who said they would chase this immediately. They confirmed they had taken action to address the issues we raised following our inspection.

Dealing with Emergencies

There were clear policies and contingency plans in place for ensuring business continuity in the event of an emergency situation. This highlighted situations which would present risks to patients and the practice such as computer system failure, telephone breakdown, loss of utilities or floods. The policy stated who would be responsible for ensuring action was taken to ensure the practice could continue to serve patients; the timeframes for response and the arrangements for evacuation and accessing alternative premises.

The practice manager told us they were a member of a federation of local practices (Optimus) and the practice manager had established positive links with other practice managers to enable and facilitate support in emergency situations. Staff we spoke with knew where the policies were kept and they told us they could access them easily. The staff contact list was not fully completed and action was needed to ensure each person could be contacted in emergency situations.

Equipment

We checked the equipment in use at the practice to make sure it had been assessed and certified as safe for use. We saw that all electrical equipment had been tested for safety and serviced. Equipment which needed calibration had been checked to ensure it was working effectively. Most of the single use items in the consulting rooms were in date, we found one or two which were not which were disposed of. The practice manager confirmed there was no-one at the practice with overall responsibility for checking such items and said they would put a system in place to address this.

We identified that there was a policy indicating that the defibrillation equipment should be checked once a week, but staff we spoke with told us this was actually completed once a month. We noted that the equipment was kept in the clinical treatment room; this would mean it may be difficult to access this life saving equipment in an emergency. We raised this with the practice manager and partners and they told us they would relocate it immediately and make staff aware of the new location to ensure this essential equipment could be accessed in an emergency. They confirmed they had taken action to address the issues we raised following our inspection.

The patients we spoke with told us the consulting rooms were well equipped and they told us they had never experienced a doctor or nurse having to leave them to look for essential equipment during a consultation. Staff we spoke with confirmed there was sufficient equipment available at the practice to undertake the diagnostic tests or to provide the treatment patients needed.

Are services effective?

(for example, treatment is effective)

Summary of findings

The care and treatment being provided to patients was effective.

The assessment, monitoring and treatment provided to patients with long- term (chronic) conditions followed current research based best practice guidelines.

The doctors and nurses working at the practice had a clear insight into the health needs of the patient population and the challenges these presented to both the patient and the practice in maintaining their health and wellbeing. There was evidence of robust clinical audits taking place to ensure positive clinical outcomes for patients.

Patients were referred to specialists where necessary and staff at the practice ensured care was co-ordinated and there was clear communication between professionals and the patient when they had complex needs or health conditions.

Our findings

Promoting best practice

Boultham Medical Centre was highlighted as being an outlier in respect of the number of patients who had a diagnosis of chronic obstructive pulmonary disease (COPD - a long term respiratory disease.) An outlier means that the numbers of patients with this condition is high when compared with other practices.

The practice employed a nurse who had specialist expertise in respiratory disease, and in each case there was evidence to show that the diagnosis was made following a spirometry test (a test that can help diagnose various lung conditions) in line with NICE (National Institute for Health and Care Excellence) research based best practice guidance. We also saw evidence that there were systems in place to ensure the diagnosis of COPD would be reviewed and changed if the spirometry test did not indicate that a patient had this condition. The diagnostic skills and expertise of the nurse had ensured that patients with symptoms suggestive of COPD were identified quickly.

We found patients who had been diagnosed with COPD through a routine well person check had been offered smoking cessation therapies; had been provided with extensive information about the condition, had been given a gym membership and were invited to attend a course on diet and lifestyle to assist them in managing their illness and preventing worsening health. Patients with life-long conditions told us they saw the nurse regularly for checks. This showed the practice was following NICE guidance and had an active management plan to educate patients in the management of this long term health condition.

Management, monitoring and improving outcomes for people

There was a system of audits in place to assure the quality of clinical care and ensure a positive outcome for patients. We saw the practice had undertaken recent clinical audits in respect of gout, contraceptive use and patient weight. They were in the process of undertaking a clinical audit of prescribing. We looked at the clinical audit for gout as the practice had completed this audit cycle. These audits were comprehensive and demonstrated the practice were reflective in their audits and took action to improve where

Are services effective?
(for example, treatment is effective)

any shortfalls were identified. The outcome of these audits was communicated to the whole staff group and staff we spoke with told us communication amongst staff at the practice was effective.

Clinical meetings were held regularly and there were standard agenda items which were always discussed including palliative care, quality and outcomes framework (QOF) (this is a voluntary incentive programme enabling GP practices to detail practice achievement results), clinical issues from doctors, nurses and pharmacists. The staff we spoke with confirmed these meetings took place and that any identified actions were discussed and any conclusions recorded. We saw records which confirmed this system was in place.

Staffing

There were clear policies and procedures in place at the practice covering staff induction, probationary periods and appraisal to ensure people working at the practice were trained and competent to carry out their specific role. We saw completed induction checklists in staff files. Each area was signed off by the manager and staff member once completed.

Every member of staff undertook specified statutory training in addition to role specific training to ensure they could undertake their role competently. Patients we spoke with told us the staff at the practice were knowledgeable, helpful and competent. There was a record of training undertaken by each member of staff in their file along with their appraisal documents and staff told us the systems in place for training and appraisal of staff worked well. Staff we spoke with told us the opportunities for their development were encouraged and supported. One of the GPs acted as a mentor to the nurse practitioner and they told us they met once a month to discuss a particular clinical need, for example prostate problems. Clinical and non-clinical staff all told us the GPs were positive about offering staff learning opportunities and doctors in training were placed at the practice for workplace based foundation training.

All of the patients we spoke with told us there were always enough staff at the practice. They told us the receptionists kept them up to date if surgeries were running late and let them know how long they would wait. A patient told us this only happened in an emergency situation (such as if an on call doctor had to go out which they had experienced). All of the patients we spoke with said they could always get an appointment if they needed one, but not necessarily at a convenient time. They also told us they could speak to the doctor or nurse practitioner if they needed to in an emergency situation. The GPs and practice staff we interviewed were confident that patients would be seen in an emergency and they used a number of strategies to achieve this cover including; emergency sessions, having a GP on call each day and offering telephone triaging with a GP. We observed these systems in practice and found the staff made every effort to ensure patients who needed to be seen had access to either a GP or a nurse practitioner.

The staff all demonstrated a willingness to provide cover in emergency situations, and there was a commitment amongst all practice staff to working together to achieve appropriate cover for patients. The practice did not use locum doctors in spite of the pressure to provide increased access to appointments at times, preferring to use their own staff and the nurse practitioner role more flexibly to ensure patients health and wellbeing was protected.

All of the practice staff told us there was a very low turnover of staff at the practice which meant there was consistency for patients. A number of patients and members of the patient participation group commented positively on the stability of the staff team and the positive impact this had on their care and treatment. Staff we spoke with told us there was managerial and peer support available.

There were policies in place to enable the practice manager to assess and manage poor performance should the situation arise. There was also a very clear policy and system in place to ensure clinical staff were registered with their appropriate professional body which the staff we spoke with confirmed was followed in practice. This ensured clinical staff continued to meet expected professional standards of practice.

Working with other services

We found the staff at the practice would take steps to ensure their patients received the care and treatment they needed from other health and social care providers in a timely, safe and appropriate way. Many patients told us their GP would follow up referrals they had made or would liaise with other health and social care providers on their behalf. We heard of examples where patients had been discharged from the care of a consultant at the hospital but continued experiencing difficult symptoms. The GP advocated for patients in such circumstances, liaised with the consultant and ensured patients were reviewed again

Are services effective?

(for example, treatment is effective)

and received the treatment they needed. We also saw evidence in the significant events monitoring forms of the practice raising complaints when their patients had received unsafe or inappropriate care.

Staff at the practice told us there were meetings with other professionals and agencies where patients with complex needs were discussed, information was shared and care and treatment planned and co-ordinated to ensure an integrated approach. This was confirmed by comments from managers in care homes, patient comments and by records of meetings. Staff reported well established links with the out of hours service. This was further enhanced as two members of staff at the practice did some sessional work for the out of hours service and because out of hours staff could access current patient records. This meant situations of risk were clearly highlighted and accessible to staff providing emergency cover out of hours and that the end of life wishes and plans of patients were accessible and inappropriate hospital admissions could be avoided.

The practice was part of a consortium of six local GP surgeries established with the aim of developing a clinical education programme to ensure better clinical involvement and co-operation between GP practices and hospital consultants. The consortium members worked collaboratively to benchmark the best clinical standards of care and to share positive clinical practice outcomes. In addition the patient participation groups (PPG) of each practice established and led their own patient participation consortium with the aim of working together to shape the future of general practice using local and national policies and their knowledge of the challenges in delivering high quality patient care. The PPG members told us they were able to share some of the work they had undertaken with the practice on getting the number of patients who did not attend their appointments down with consortium members who were looking to do similar things in their own practice.

Health, promotion and prevention

The practice had a policy indicating how they would identify and support carers. There was a section on new patient registration forms to enable people to identify themselves as a person providing care for a relative, friend or neighbour. We observed that there were information leaflets and an information pack available for carers in the practice and that the practice website signposted them to information and services to assist and support them in their caring responsibilities. One of the patients we spoke with was a carer for their relative and they told us that they were very happy with the care, support and treatment they both received from the practice. They told us they felt well supported in their caring responsibilities.

The patient registration packs were seen and were comprehensive and screened patients for risk factors in their medical and social history. We observed staff at the practice go through the registration procedure with patients and all new patients were given information about the practice and about the patient participation group. The practice website provided clear guidance for all new patients (including the registration of children) and indicated what information and documents would be needed to register at the practice. It also made clear that all new patients must be seen by the practice nurse for a full new patient check including having diagnostic tests to identify any health needs.

We observed there was a comprehensive range of information available for patients of the practice, including information about specific illnesses such as the signs of ovarian cancer, pressure ulcers, meningitis, arthritis and blood clots. There was information about groups and services aimed at health promotion such as walking groups and smoking cessation groups.

Are services caring?

Summary of findings

The service was caring with all staff displaying an exemplary attitude towards patients and their care and treatment. We saw examples of GPs going the extra mile to advocate on behalf of their vulnerable patients with other agencies.

The feedback from patients and staff in care homes was (with one exception) positive. Patients told us they were happy with the quality of the care and treatment they received at the practice.

Our findings

Respect, dignity, compassion and empathy

All of the patients we spoke with told us intimate examinations were done in private and in a way they felt comfortable with. All staff and patients we spoke with were aware of the chaperone policy, but most of the patients told us they elected to see a GP or nurse of the same gender if they needed an intimate examination. They told us these preferences were always facilitated by practice staff to ensure their personal dignity was maintained.

The majority of patients registered at the practice were white, British. We spoke with some patients whose first language was not English and they told us they usually used a family member to interpret for them. The family member was a young person and we were concerned it may not always be appropriate to involve them, especially if the doctor had to break bad news. We asked staff about access to the interpreting service and they were unsure how to access this due to changes within local healthcare funding. We provided some information to the practice about accessing interpreters as needed to ensure clear communication could take place between practice staff and patients needing translation services.

There was a commitment to protecting patient confidentiality at the practice. All staff received training about the Caldicott Principles as part of their induction. These principles govern how practices access, use and share information which identifies individual patients. The practice had a clear desk policy and we saw this was followed and all confidential patient information was cleared when rooms were vacated. Patients felt confident that information about them and their health and wellbeing was secured appropriately.

An analysis of information showed us that there was a locally higher prevalence of hospital admissions of patients following self-harm. The practice staff had an excellent knowledge, understanding of and commitment to this vulnerable group of patients. We saw evidence to show GPs advocated strongly for their patients with other organisations to ensure that those experiencing mental ill health were not placed under undue pressure which may increase feelings of despair or hopelessness and may lead to an increased likelihood of self- harm taking place.

Are services caring?

The practice worked closely with the palliative care team as patients approached the end of their life and we saw records which demonstrated collaborative working took place. Staff at the practice told us they worked to the gold standards framework (GSF) goals. The GSF aims to improve the quality of palliative care available in the community. It enables patients approaching the end of their life to live and die well and to avoid inappropriate admissions into hospital where this is against their expressed end of life wishes. It involves; control of symptoms, supporting people to die where they choose and with dignity, providing advanced care planning and avoid hospital admission, supporting carers and co-ordinating care. We did not speak with anyone approaching the end of their life, or providing care to patients in these circumstances, but we did speak with people with life long (and potentially life limiting) conditions who told us the doctors and nurses broke the news to them in a sensitive and caring way. There was information in the reception area, in information packs and on the practice website signposting patients and carers to extra help, information and support.

The practice had a separate waiting room available for children, young people and families if they chose to use it. The room had a notice board with information specifically targeted at this group of patients, such as information about family centres, breastfeeding and information directed at teenagers attending the health centre. We spoke with a patient who was attending with their child who had brought the child to see a specific doctor as they felt the GP had a kind manner with children and young people and was reassuring to them and their child.

Involvement in decisions and consent

All but one of the patients we spoke with or received comments from told us they were treated with respect and as partners in their health care and treatment. Patients told us they felt listened to by staff at the practice and they told us they had received information about their illness or disability in various ways, including in writing and verbally. All of the patients we spoke with told us the practice staff answered any queries they may have and several told us they had never left the practice with any unanswered queries. One patient told us the GP with a special interest (dermatology) was very knowledgeable. The patient said the GP had provided verbal information, showed them a book explaining their condition and had prescribed some medicine which had cleared the symptoms. Patients therefore felt they were treated respectfully and with compassion, and as a result they felt fully involved in their care and treatment.

The majority of patients we spoke with had a preferred doctor and they told us reception staff tried to accommodate their preferences to provide the best possible service. We observed this happening in practice.

The staff we spoke with were aware of the Mental Capacity Act and consent issues in respect of children, young people and adults. They were aware of how this would be affected if the person had (for example) dementia or a learning disability which may affect their ability to retain and weigh certain complex information and how this would affect their ability to give informed consent to any proposed care or treatment. The care homes we spoke with told us the GPs would review DNAR CPR (do not attempt cardio-pulmonary resuscitation) orders regularly or if the care home staff requested this to make sure it was still appropriate and right for the patient not to receive life saving treatment in an emergency situation.

Patients we spoke with told us the staff always provided clear explanations about any tests or treatment, the reason for these and why they were being done. They told us their consent to these tests and treatment was informed.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to patients' needs. The patient participation group (PPG) told us the staff at the practice listened to them and valued their work.

We saw the results of the recent patient survey and these were very positive in all areas indicating high levels of patient satisfaction with the service.

Patients had the choice of male and female GPs and the premises were accessible to patients with disabilities. Information about the service was displayed and available on the website including information targeted at specific patient groups. The practice provided on line services, text reminder services and provided an extensive range of information for patients on their website and in the practice itself.

Complaints were investigated and responded to and lessons were learned to improve practice.

Our findings

Responding to and meeting people's needs

The staff we spoke with told us the doctors "bend over backwards" for their patients. They told us of changes they had made to the service to try and make improvements for patients. For example the timeslots for the first time a parent attended baby clinic had been extended from 10 to 15 minutes to make sure all of the necessary tasks could be undertaken and to avoid rushing new parents. We spoke with parents of young children as part of this inspection and they told us the doctors and nurses listened to them, had time for them and their concerns and were reassuring with their children.

The doctors and nurses working at the practice had a clear insight into the health needs of the patient population and the challenges these presented to both the patient and the practice in maintaining their health wellbeing. Some patients at the practice lived in deprived circumstances and had drug or alcohol dependency and the GPs had a clear understanding of the local organisations available to provide support, advice and treatment for patients with these needs. The practice had robust systems in place for requesting and issuing prescriptions for controlled drugs which meant they were less likely to be misused. We saw there was information available in the waiting area about needle exchange services. This ensured patients who had drug dependency were signposted to places where they could obtain clean needles; reducing the risk of acquiring infections which presented significant risks to their health.

The doctors and nurses told us the practice had a higher number of older patients who were attending the practice or needing home visits more frequently. The nurse practitioner told us they saw a number of older patients who did not have any contact with other agencies or professionals and provided clinical care as well as a listening ear. They told us GPs always visited on request, in the majority of cases on the same day.

We spoke with the managers of four care homes (for older people or younger adults with disabilities) whose patients were registered at the practice and they told us the practice staff were very responsive to their patients' needs. They all told us they would recommend the practice to the vulnerable people in their care. The care home staff told us the doctors visited the care home and did not expect patients to go to the practice (unless that was their wish).

Are services responsive to people's needs?

(for example, to feedback?)

They told us the GPs would review people with complex needs or care plans and would support care home staff in in complex or difficult situations and made referrals for specialist assessment promptly to make sure patients received expert assessment and treatment.

Staff working at the practice had an awareness of the Mental Capacity Act and of the need to try and provide patients with information in a way they would understand. Feedback from patients and care homes indicated that the practice staff tried very hard to make sure patients understood their needs, what tests were being proposed and why.

All of the patients we spoke with told us that referrals were made in a timely way and we saw this in practice. The reception and administrative staff were very efficient. Patients told us GPs would advocate on their behalf with hospital services if referrals were not being actioned promptly and we saw evidence of this in records held at the practice when we inspected. Care home managers reported they had to chase test results rather than the practice pro-actively telling them about these and they felt this was the only thing which could improve the service at the practice. Most patients we spoke with were happy with the systems in place for obtaining test results and they said the doctor would ask them to come in if there were any abnormalities in their results.

The majority of the patients at the practice were white, British, with the largest minority ethnic patient group served being Eastern European. The practice website provided information to patients about healthcare services in a number of languages, including Albanian, Bulgarian, Croatian, Lithuanian and Polish. We found that the practice staff did not have a clear understanding about how to access interpreting and translation services once the patient was registered with them following changes to NHS funding. This could result in patients using family members or friends to interpret which may not always be appropriate. We provided some information about how to access these services to enable the practice to provide interpreting and translation services to their patients when needed.

The practice was accessible for all patients with parking for people with disabilities; level access adapted toilets and a vertical lift. There was a waiting area for parents with children or for young people with information relevant to those groups as well as baby changing and breast feeding facilities.

The practice website provided comprehensive information about the clinics and services the practice provided to meet the needs of its patient population, this included clinics which would be routinely available in most practices such as cervical smears and child vaccinations to ones which were more specialised such as minor surgery. There were sections on the website directed at specific groups such as teenagers, parents and people with long term conditions. The website also contained links to information and support for specific patient groups such as carers, families and provided information about self-management of minor illness for working age patients.

Access to the service

The GPs and other practice staff were aware of the challenges the appointment system presented for working age patients. As a result of this knowledge they had introduced a number of initiatives to try and improve access for these patients. These initiatives included telephone triage, developing an on call system and arranging for extended opening hours offering pre-bookable appointments one evening a week and on Saturday morning. The working age patients we spoke with appreciated these developments and told us they could usually get an appointment when they needed one.

Patients were able to book appointments in advance, by telephone or by turning up at the practice on the day. The reception and nursing staff told us the GPs were committed to their patients and never turned anyone away. We saw this system operating in practice on the day of our inspection and staff confirmed the on call surgery would carry on until all patients were seen. The on call surgery was a system in place to ensure there was a doctor or practice nurse available during opening hours who could see patients without an appointment in an emergency situation.

The practice used their nurse practitioner flexibly to increase their appointment capacity. The reception staff told us this had been a very successful initiative, allowing GPs to focus on emergencies whilst at the same time ensuring patients with less urgent but still important symptoms were seen promptly. The practice also used an on call doctor system and offered telephone triaging with

Are services responsive to people's needs?

(for example, to feedback?)

both the on call doctor and the nurse practitioner. These systems showed the flexibility of the practice staff and demonstrated their commitment to providing access for patients who needed to speak to a clinician.

Home visits were available and were undertaken by both doctors and the nurse practitioner; these visits were reserved for people with disabilities or those who could not or would not leave their house to attend the practice due to illness or disability. This resulted in these appointments being kept for those who were most vulnerable and in need of the service.

Efforts and success in reducing DNAs has been a major initiative proposed and supported by PPG to improve access for patients. Patients who missed appointments were written to and asked to cancel their appointments in future and this and the text reminder system had resulted in a dramatic reduction in the number of patients who did not attend appointments. The benefit of this was in releasing more appointments to patients who needed them.

Concerns and complaints

The practice had a system in place for patients to make complaints or comments about the service they received. This was displayed in the practice and on the practice website. The practice website also contained links to the ombudsman service and to the NHS complaints advocacy service. In addition to this formal system there was a suggestions box in the reception area to enable patients to make comments and express ideas about how the service could improve.

We looked at the records of complaints which had been received at the practice during the last year and these were all recorded, acknowledged, investigated and responded to in line with the provider's policy.

The practice manager provided an annual complaints review which was dated 24 March 2014. This indicated there had been 6 formal complaints which had all been resolved to the satisfaction of the patients. There were no repeated patterns of complaints nor patterns of complaint about particular practice staff. Staff we spoke with told us the learning from complaints was discussed with the whole staff team to enable them to learn from these and make changes to approach and practice where needed. The complaints review indicated that feedback was given to named members of staff where appropriate. Identified learning from complaints was recorded as being; to be prompt, fair and objective in all interactions with patients; to make every attempt to resolve complaints by responding quickly to complaints and to continue to work on the appointment system to improve access for patients. The records and comments from staff demonstrated an open and transparent approach to complaints and a desire to continue to develop the service for the benefit of patients.

Are services well-led?

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

Summary of findings

The service was well-led in most respects. There were visible and responsive leaders and a culture of openness where all staff felt valued, respected, able to express their views and be heard. All practice staff had shared vision and values and there was an expectation of high standards of patient care.

The practice manager provided strong leadership; but the roles and responsibilities of different staff members needed clarifying to ensure the systems in place at the practice were effective and minimised the risks to patients, staff and others.

Our findings

Leadership and culture

The practice manager and GP partners provided visible, supportive and clear leadership in addition to modelling professional practice and responses to patients. This was evident from comments from patients, staff, observations in discussion with them and in records. All of the staff we spoke with told us there was an open, transparent and supportive culture at the practice and an expectation of high standards of service delivery. Staff told us they could ask any question, raise concerns and make suggestions and they would be listened to and responded to. We saw there was a document explaining expected standards of work and behaviour and this was on display in the staff room.

The whole practice team had shared visions and values; all staff understood the challenges their patients faced, particularly those in deprived circumstances or in vulnerable situations and they were proud of the work they did to improve the health of their patients. The records we saw and comments from staff and patients showed the GPs advocated strongly for their patients to ensure their health and wellbeing was protected. Interviews with staff and the patient participation group (PPG) indicated the practice manager and GP partners worked collaboratively with others both internal to the practice and externally to continually improve their service. The patient participation group are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

The practice manager was intending to leave the practice and the GPs and the staff team told us he had set a high standard which they wished to maintain. They were starting the process of recruitment and had invited the practice manager to be involved in selecting their successor in anticipation that he would identify the skills, knowledge and abilities needed to manage the practice efficiently and drive improvements.

Governance arrangements

The policies and procedures underpinning all areas of the service provided at the practice were up to date and clear. These documents provided guidance for staff who confirmed the documents were accessible to them. We found the policies were not always fully implemented in practice.

Are services well-led?

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

The practice manager was named by staff and in records as the person responsible for most of the day to day practice decision making, risk analysis and management and for assessing overall quality of the service. It was clear the partners and practice staff relied heavily on the practice manager and staff told us the practice manager was responsible for most issues. The practice manager had delegated some responsibilities to others (for example he had encouraged the PPG to take the lead in managing their own meetings and work). However, we found that the roles and responsibilities of the whole practice team needed to be made more explicit to ensure oversight of systems and processes and to prevent risks to patients. For example to ensure checks on the defibrillator were done weekly in line with the policy.

There was a clear commitment from the practice leadership team to develop the competence of their workforce with a view to improving patient care. The practice was an approved by Health Education East Midlands as an accredited training practice providing work based placements to doctors in training. One of the GPs was an accredited trainer having a post qualification certificate in medical education and staff were proud to be a training practice. The training programme enabled all staff to have some common training as well as learning and development opportunities which were specific to their role. Being a member of the consortium of six practices had offered further opportunities for personal development for staff as had the system of mentoring available to the nurse practitioner. Staff we spoke with told us the training available offered them opportunities for continued professional development and to improve their practice.

Systems to monitor and improve quality and improvement

The practice was awarded the Quality Practice Award by the Royal College of Practitioners in 2011. This is an award which is given to practices to show recognition for high quality patient care by all members of staff in the team. To achieve the award, the practice had to provide evidence to show they were meeting set criteria in 21 areas, including clinical care, communication and practice management. The staff team were proud to have achieved this award.

We found a great deal of work went into ensuring all staff were aware of the clinical skills of people working at the practice. Staff we spoke with told us there was a written list of the skills of each team member available to reception staff and we saw this displayed. This system enabled reception staff to book each patient in with the staff member with the appropriate skills to meet their needs.

The leadership team had a system of auditing in place and there was evidence to show they analysed all available information, including comments and complaints from staff, patients and others to enable them to form an opinion about the quality of the service being provided. There was an analysis of trends, and learning points were actively considered and discussed with the whole practice team to improve the service provided to patients. Our discussions with the staff and leadership team provided evidence that there was no sense of complacency at the practice and they were looking to continuously improve the quality of their service

Patient experience and involvement

The PPG had a fundamental role within the practice and they told us they were valued and encouraged by the practice's leadership team to operate with independence and autonomy in representing the views and interests of patients at the practice. The PPG had put systems in place to obtain patient views including having personal contact with patients at the practice, having a separate section dedicated to their work on the practice website, producing a newsletter and more recently having a display in reception to recruit new members.

We met with six members of the patient participation group (PPG) who told us the practice valued and listened to them, they told us the practice manager kept them well informed and had encouraged them to lead and direct their own meetings, representing the patient voice. A named GP attended their group meetings and all partners provided reports for the PPG on their area of interest or expertise. Members of the PPG told us they were actively recruiting patients from all population groups and information on the practice website provided the demographic of the current PPG. The PPG had their own section on the website as well as a recruitment display in the practice and produced a newsletter for patients. They described their relationship with the practice staff as "a two way process," and they told us the GPs and practice staff were honest with them and committed to working to improve the service.

A patient survey was undertaken in January 2014 and members of the PPG collated the patient survey results and produced a report for patients and the practice. The PPG

Are services well-led?

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

compared current and previous survey results to identify areas where patients felt the practice had improved as well as those areas where patient satisfaction had reduced. These results were published on the practice website. These results indicated that 90% of respondents felt there was a genuine willingness on the part of GPs in the practice to improve the service provided to patients. 91% of respondents stated they would recommend the practice to friends and 88% gave the practice an overall rating of 8 or above out of 10. The results demonstrated high levels of patient satisfaction. The practice leadership team had responded to the survey results in the PPG's report and had highlighted the actions they would take to improve. This demonstrated they took action in relation to patient feedback with a view to improving the service. The action plan was published on the website and demonstrated a commitment from all practice staff to listen and improve services for the benefit of patients.

Staff engagement and involvement

All of the staff we spoke with felt valued and respected by the leadership team. They were encouraged to express their views and told us they felt confident to raise any concerns. They told us the practice manager had an open door policy and they reported a healthy and open culture at the practice. This was reinforced by the practice manager who told us it was for each member of practice staff to identify and raise any significant or untoward incidents which affected or had the potential to affect patient care or safety. We saw these forms were completed by different designations of staff, demonstrating a collective and shared sense of responsibility for ensuring patient safety was in place at the practice. Records showed that where staff raised any issues these were discussed openly at meetings and staff were encouraged to be involved in deciding on the action needed to prevent incidents recurring.

Learning and improvement

The records of complaints and significant events demonstrated that these systems helped the staff and leadership team learn from untoward incidents by recognising real or potential risks to patients, staff or others. The analysis of these records and events and enabled the practice team to bring about improvements in patient care by identifying where changes to practice were needed. The analysis of these events and complaints in several cases was thorough and honest and demonstrated the leadership's commitment to learning lessons when things went wrong. For example, in one situation the GPs had learned that they needed to undertake certain diagnostic examinations to rule out possible diagnoses and minimise the risks to patient health when patients presented with a specific range of symptoms. This represented reflective and analytical practice aimed at ensuring the health and welfare of patients.

Identification and management of risk

We saw evidence to show that risks to patients as individuals had been highlighted and assessed to minimise the risk of harm. The practice had employed a company to identify and assess all health and safety risks to patients and staff at the practice but they had not started the work when we did our inspection. The work was due to start imminently and it was anticipated that this would provide a systematic way of ensuring such risks were being effectively managed so there was no negative impact on patient care.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Our findings

Patients over the age of 75 could have a health check every year.

The doctors and nurses told us the practice had a higher number of older patients who were attending the practice or needing home visits more frequently. The nurse practitioner told us they saw a number of older patients who did not have any contact with other agencies or professionals and provided clinical care as well as a listening ear.

The practice worked closely with the palliative care team as patients approached the end of their life and we saw records which demonstrated collaborative working took place. Staff at the practice told us they worked to the gold standards framework (GSF) goals.

We spoke with the managers of four care homes (for older people or younger adults with disabilities) whose patients were registered at the practice and they told us the practice staff were very responsive to their patients' needs. They told us the GPs would review people with complex needs or care plans and would support care home staff in difficult situations.

The practice was accessible for all patients with parking for people with disabilities; level access adapted toilets and a vertical lift.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Our findings

Boultham Medical Centre was highlighted as being an outlier in respect of the number of patients who had a diagnosis of chronic obstructive pulmonary disease (COPD - a long term respiratory disease.) An outlier means that the numbers of patients with this condition is high when compared with other practices. We identified that the high incidence was due to a high incidence of COPD locally prompting need for specialist nurse. There were systems in place to ensure patients were regularly monitored and provided with extensive information about the condition along with opportunities to improve their health through education on diet, exercise and smoking cessation.

The GPs undertook clinical audits to assess how they were performing when compared with best practice guidance and clinical standards. The audits were comprehensive and demonstrated an ongoing commitment to learning and improving.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Our findings

The practice had a separate waiting room available for children, young people and families if they chose to use it. The room had a notice board with information specifically targeted at this group of patients, such as information about family centres, breastfeeding and information directed at teenagers attending the health centre.

We observed there was a robust system in place at the practice to flag child protection concerns which ensured all practice staff were alerted to the potential risks to each child who may be vulnerable to harm or abuse. This flagging system was applied to the patient records of all family members to ensure crucial information about early detection was not missed. The senior partner told us the out of hours service was also able to access the contemporary patient records from the practice which meant they were also alerted to any information about the risks of harm or abuse for vulnerable children.

The practice staff were responsive to mothers, babies and young children and had made changes to the way they worked to accommodate their needs. For example, the timeslots for the first time a parent attended baby clinic had been extended from 10 to 15 minutes to make sure all of the necessary tasks could be undertaken and to avoid rushing new parents. We spoke with a patient who was attending with their child who had brought the child to see a specific doctor as they felt the GP had a kind manner with children and young people and was reassuring to them and their child.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Our findings

People over the age of 45 were offered well man or well woman checks to look for early signs of life long illnesses, or worsening physical or mental health. Some patients told us these routine appointments had led to them being diagnosed early with long term health conditions and they had been able to learn about how they could improve their own health.

The GPs and other practice staff were aware of the challenges the appointment system presented for working age patients and as a result had introduced a number of initiatives to try and improve access for these patients including telephone triage, developing an on call system and arranging for extended opening hours offering pre-bookable appointments one evening a week or on a Saturday morning. The working age patients we spoke with appreciated these developments and told us they could usually get an appointment when they needed one.

There was a range of information available to working patients or those who had recently retired in the practice and on the practice website. The website provided information about self-management of minor illness for working age patients to avoid the need for them to attend the practice if this were not needed.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Our findings

The GPs told us that some of their patient population had a dependence on drugs; we looked carefully at the management of medicines to make sure these systems were safe and patients were protected from harm. There were no patterns of untoward incidents involving medicines. This system was especially robust in respect of controlled drugs (CDs). Controlled drugs are medicines which are subject to extra controls as there is a potential for them to be misused or obtained illegally causing potential harm.

The doctors and nurses working at the practice had a clear insight into the health needs of the patient population and the challenges these presented to both the patient and the practice in maintaining their health wellbeing. Some patients at the practice lived in deprived circumstances and had drug or alcohol dependency and the GPs had a clear understanding of the local organisations available to provide support, advice and treatment for patients with these needs. We saw there was information available in the waiting area about needle exchange services. This ensured patients who injected drugs were signposted to places where they could obtain clean needles; reducing the risk of acquiring infections which presented significant risks to their health.

The majority of patients registered at the practice were white, British. We spoke with some patients whose first language was not English and they told us they usually used a family member to interpret for them. The family member was a young person and we were concerned it may not always be appropriate to involve them, especially if the doctor had to break bad news. We asked staff about access to the interpreting service and they were unsure how to access this due to changes within local healthcare

People in vulnerable circumstances who may have poor access to primary care

funding. We provided some information to the practice about accessing interpreters as needed to ensure clear communication could take place between practice staff and patients needing translation services.

Home visits were available and were undertaken by both doctors and the nurse practitioner; these visits were reserved for people with disabilities or those who could not or would not leave their house to attend the practice due to illness or disability. This resulted in these appointments being kept for those who were most vulnerable and in need of the service.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Our findings

The Lincolnshire area health profile highlighted that hospital stays caused by self-harm were significantly higher than the England average. For this reason we looked at how the practice identified and responded to patients with depressive illnesses. The practice staff had an excellent knowledge, understanding of and commitment to this vulnerable group of patients. We saw evidence to show GPs advocated strongly for their patients with other organisations to ensure that those experiencing mental ill health were not placed under undue pressure which may increase feelings of despair or hopelessness and may lead to an increased likelihood of self- harm taking place.

GPs told us they made use of information provided by patients about (for example) stress and information about their personal circumstances. They told us they also used recognised assessment tools to monitor the severity of depression and the patient's response to treatment. They told us this enabled them to assess and respond appropriately to risk. Records we saw confirmed that there was careful monitoring of patients' mental health, and referrals were made for specialist support as appropriate to ensure patients were received the help; support and treatment they needed to maintain their health and safety. Analysis of adverse events demonstrated that there was a considered and robust approach towards looking at clinical practice, missed opportunities for engagement and learning lessons to improve practice and ensure risks were monitored.

Staff at the practice told us there were meetings with other professionals and agencies where patients with complex needs were discussed, information was shared and care and treatment planned and co-ordinated to ensure an integrated approach. This was confirmed by comments from managers in care homes, patient comments and by records of meetings.