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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Fosse Medical Centre on 6 January 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example this included the employment of a physiotherapist for seven hours a week in the practice. Therefore reducing the waiting times for appointments and resulting in patient's ability to return to health and work sooner.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Reference Group (PRG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. This included the

employment of a physiotherapist for seven hours a week in the practice. Therefore reducing the waiting times for appointments and resulting in patient's ability to return to health and work sooner.

- The practice noted the high admission rates to Accident & Emergency locally from East European patients and as a result they included information in a Polish newsletter for patients on when they should or should not attend A & E.

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?

Good

The practice is rated as good for providing safe services.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who that lead was and who to speak to in the practice if they had a safeguarding concern.

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from NICE (National Institute for Health and Care Excellence) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current guidance and legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. All staff had received appraisals and had personal development plans.

The practice work closely and effectively with multidisciplinary teams this included district nurses, health visitors, midwives and other health care professionals.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

We found the practice provided good care to older people, people with long term conditions and people in vulnerable circumstances. They provided good care to families, children and young people, working age people and people experiencing poor mental health.

We found that the practice routinely assessed the mental capacity of patients and that all patients that were deemed to lack capacity including those with a diagnosis of dementia had advocates appointed to act in their best interest.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. This included the employment of a physiotherapist for seven hours a week in the practice. The latter helped reduce waiting times for appointments and resulting in patients ability to return to health and work sooner.

The practice was also open from 7.00am – 6.30pm on Monday, Wednesday, Thursday and Friday, and from 8.00am - 6:30pm on Tuesday. These extended hours gave improved access for patients especially for those of working age.

The practice were aware of the needs of its population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

We found the spiritual, ethnic and cultural needs of the practice population were being met. For example the practice had a significant number of Polish patients, as a result a newsletter was produced by the practice in Polish and they have two Polish members of staff. There is also a small Asian population and the GPs speak a number of Asian languages.

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction.

The practice noted the high admission rates to Accident & Emergency locally from east European patients and as a result they included information in the Polish newsletter for patients on when they should or should not attend A & E.

The practice had a very active patient reference group (PRG) which had steadily increased in size to 12 members. The PRG met quarterly with attendance from GP's and the practice manager. Meetings were minuted and available to the patients newsletter which the PRG produced four times a year. Among other information in the newsletter were the figures for patients who did not attend appointments, patients were reminded that reception should be informed. The PRG also assisted at flu clinics and had been trained to record blood pressures, height and weight measurement from the automated testing machine that was located in the waiting room and memory tests for those patients who wished it.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice provided a dedicated telephone number in case patients had difficulties accessing the reception contact number to discuss concerns with a GP.

There was a named accountable GP for all patients over the age of 75.

People with long term conditions

Good

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

The nursing team at the practice had been fully trained in long term condition management, including independent prescribing and insulin initiation. There were also GP leads for these.

An emergency, dedicated telephone number was issued to patients at high risk of emergency admission.

Families, children and young people

Good

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. There was a health visitor attached to the practice and there was a standard invite for them to attend weekly meetings or drop by at any time. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were

recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

All staff within the practice had completed safeguarding of children and vulnerable adult training. They had also all completed e-learning on the mental capacity act.

Working age people (including those recently retired and students)

Good

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 offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice also offered urgent on the day appointments and telephone advice.

The practice was also open from 7.00am – 6.30pm on Monday, Wednesday, Thursday and Friday,and from 8.00am - 6:30pm on Tuesday. . These extended hours gave improved access for patients especially for those of working age

The practice offered in house physiotherapy, counselling, phlebotomy, minor surgery including joint injections and INR services (The international normalised ratio (INR) is a measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants on the clotting system).

People whose circumstances may make them vulnerable

Good

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability. People identified as homeless or vulnerably housed were usually referred to Inclusion Healthcare Social Enterprise CIC in the city as that provided high quality primary health care services for homeless people. .

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

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

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

Patients had access to a Serious Mental Health Practioner who attended the surgery one day each week via community health services.This was as a result of identified mental health issues that presented at the practice.

Summary of findings

What people who use the service say

We spoke with six patients in the reception and waiting areas of the practice including patients from a number of different practice population groups.

The majority of the patients we spoke with were very happy with the service they received. They told us that the GPs and the nurses were caring, patient, kind and treated them with respect. Patients told us the were much happier with the new access to appointments that had been put in place.

Patients had completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive regarding getting through on the phone to book appointments.

In the latest National GP patient survey results on this practice 357 surveys were sent out and 114 were returned, of those, 79% of respondents with a preferred GP usually got to see or speak to that GP, 86% of respondents were satisfied with the surgery's opening hours and 70% and 90% of respondents say the last nurse they saw or spoke to was good at involving them in decisions about their care. These results were all well above the CCG average.

Outstanding practice

- We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. This included the employment of a physiotherapist for seven hours a week in the practice. Therefore reducing the waiting times for appointments and resulting in patient's ability to return to health and work sooner.
- The practice was also open from 7.00am – 6.30pm on Monday, Wednesday, Thursday and Friday, from 8.00am - 6:30pm on Tuesday and from 8.00am – 1.00pm on Saturday and Sundays. These extended hours particularly those at weekends gave much improved access for patients especially for those of working age.
- The practice noted the high admission rates to Accident & Emergency locally from East European patients and as a result they included information in the Polish newsletter for patients on when they should or should not attend A & E included in this was reference to the extended hours at the practice.

Fosse 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 and a practice manager.

Background to Fosse Medical Centre

Fosse Medical Centre delivered primary care under a Personal Medical Services (PMS) Contract between themselves and NHS England. As part of the NHS Leicester City Clinical Commissioning Group (LCCCG), they serve the area of Leicester City West, with over 8,300 patients.

There are five consulting rooms on the ground floor for Doctors and Nurses. Consulting rooms are located on the first floor and practice administration rooms are located on the second floor. The practice has ramps to the front and rear entrances of the building, with automatic doors that are suitable for wheelchair access. There is a disabled person's toilet and baby changing facilities located on the ground floor.

Just over 42% of the practice population are of the working age group those under the age of 18 measured at nearly 41%, those over the age of 65 are in the minority at just over 17%.

There are three male and one female GP. The nursing team consisted of an advanced practitioner nurse, practice nurse, three health care assistants. A physiotherapist employed by the practice was also available.

The surgery is open from 7.00am – 6.30pm on Monday, Wednesday, Thursday and Friday and from 8.00am - 6:30pm on Tuesday.. The clinical sessions of individual doctors and nurses vary within these hours. The practice GPs do not provide an out-of-hours service to their own patients and patients are signposted to the local out-of-hours service when the surgery is closed. This service is provided by Leicester City, Leicestershire and Rutland Out of Hours and is run by Central Nottinghamshire Clinical Services Limited.

The practice offers a full range of general medical services including maternity, child health, vaccination, blood testing, contraception, chronic disease management, warfarin and disease modifying anti-rheumatic drug monitoring. Treatment room services include travel vaccination services in addition to the child vaccinations. Leg ulcer management, minor injuries and minor illness advice is also offered by the practice nursing service.

There was a full time practice manager, senior receptionist/deputy manager, seven reception staff and a medical secretary. Patients told us the practice was well managed.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act 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.

Detailed findings

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, 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?

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

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

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked NHS Leicester City Clinical Commissioning Group (LCCCG) and the Local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 6 January 2015. During our inspection we spoke with all the staff available on the day. This included the three GP partners, one practice nurse, the practice manager, two administration staff, two members of reception and a health care assistant. We spoke with five patients who used the service and the chairperson of the patient participation group. We reviewed comments from 21 CQC comments cards which had been completed. We observed interaction between staff and patients in the waiting room.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

The practice manager was aware of notifiable incidents that needed to be reported to the CQC.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. The significant events reporting folder was available on the practice computer and also backed up on a memory stick. Significant events were a standing item on the weekly practice meeting agenda. If a particular action or response had required immediate action on the day this would have been discussed at the partner and practice manager meeting that is held each day. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms saved on the practice intranet and sent completed forms to the practice manager. They showed us the system they used to manage and monitor incidents. We saw a copy of the practice safety alert protocol and the significant event toolkit. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding and the Mental Health Act. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who that lead was 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. This included information to make staff aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

All GPs and staff had undertaken the safeguarding training in regard to vulnerable children and adults. As a result of further discussion by the GPs all staff had received domestic violence training.

Good

Are services safe?

All GPs had a "usual doctor" list that enabled them to keep track of vulnerable persons and discuss at practice meetings. We were told that same day telephone consultations with those patients took place when required.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Receptionists had also undertaken training and had been DBS checked. They understood their responsibilities when acting as chaperones.

National patient safety alerts were disseminated by the practice manager to practice staff.

Special patient notes are inputted on to the computer system (Systm1); these can be accessed by out of hours teams if required. Special notes, which are valid for up to 12 months, are for the patients who may need follow up intervention out of normal GP opening hours, be at risk to themselves or others or cannot manage their healthcare themselves.

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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 waste regulations.

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

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 GPs did not carry emergency drugs whilst on visits. We were told that this was because of the proximity of the practice to the local A&E department and ambulance response times were good in the area. The system also therefore eliminated the chance of those drugs being stolen.

Cleanliness and infection control

The premises were clean and tidy. There were cleaning schedules in place and cleaning records were kept. We spoke with patients who told us they always found that the practice was clean. They had no concerns about cleanliness or infection control within the premises.

There was a lead for infection control who had undertaken further training. This enabled them to provide advice on the practice infection control policy and carry out training for all practice staff. All staff received induction training about infection control and received annual updates. We saw documented evidence that the infection control lead had carried out audits for each of the last three years and that any improvement actions that had been identified were completed on time.

The infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment was available for staff to use. There was also a policy for needle stick injury and spillage kits which could be used in the event of spillages such as blood or vomit.

There were notices about hand washing techniques 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 (a germ found in the

environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, photograph, two references, national insurance details, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All clinical staff had been DBS checked. The practice used Locum GPs very rarely (a locum GP is a GP who works in the place of the regular GP when that GP is absent, or when a practice is short-staffed). All locums were checked to ensure they appeared on The National Performers List (this provides an extra layer of reassurance for the public that GPs practising in the NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service and the NHS Litigation Authority).

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 that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

We were told by staff that there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy.

Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. They were aware of the most appropriate person to report their concerns to.

We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service**.**

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

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

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use. The defibrillator was accessible and staff carried out regular checks on the battery and the associated equipment.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks were identified and mitigating actions recorded to reduce and manage the risk

The practice also had laptop computers which meant that key members of staff could work from home.

Risks associated with service and staffing changes were included on the practice risk log. For example planning and training sessions were implemented and reviewed during appraisals. Key monthly dates were held in the practice calendar to which all staff had access. Practice insurance provided payment for the absence of key personnel.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice held a General Medical Services (GMS) contract with NHS England for delivering primary care services to their local community

Care and treatment was delivered in line with recognised best practice standards and guidelines. GPs demonstrated an up-to-date knowledge of clinical guidelines for caring for patients. There was a strong emphasis on keeping up-to-date with clinical guidelines, including guidance published by professional and expert bodies such as the current best practice guidelines from the National Institute for Health and Care Excellence (NICE) and from local health commissioners. The practice undertook regular reviews of their referrals to ensure current guidance was being followed.

The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease, asthma dermatology and muscular-skeletal problems. Practice nurses and a physiotherapist supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of conditions.

Nationally reported data taken from the Quality and Outcomes Framework (QOF) for 2013/14 showed the practice had achieved maximum points (with an overall score of 99.2%) for most of the 20 clinical conditions covered. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions such as diabetes and implementing preventative measures. The results are published annually.)

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

Discrimination was avoided when making care and treatment decisions. Interviews with all staff showed that the culture in the practice was that all patients were cared for and treated based on need only. In providing that care the practice took account of a patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. All the staff we spoke with were actively engaged in activities to monitor and improve quality and outcomes for patients. For example we were shown a number of examples of staff working with multi-disciplinary teams to improve outcomes for patients.

The practice showed us six clinical audits that had been undertaken in the last two years. Two of these were completed audits into warfarin and insulin. The practice was able to demonstrate the changes made since the initial audit. The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following an alert from the National Patient Safety Agency (NPSA) regarding actions that can make anticoagulant therapy safer an audit was carried out. The aim of the audit was to ensure that all healthcare organisations had written procedures and clinical protocols for the safe use of oral and injectable anticoagulant therapy. We saw that the practice had copies of procedures, clinical protocols, dates of Drugs and Therapeutics Committee approval including review dates.

One of the recommendations was that safe practice was promoted with prescribers and pharmacists to check that a patient's international normalised ratio (INR is a laboratory measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants on the clotting system) was being monitored regularly and that the INR level was safe before issuing or dispensing repeat

Good

Are services effective?

(for example, treatment is effective)

prescriptions for oral anticoagulants. The action taken was that an audit was performed every 1 -2 weeks using INR Star reporting software. All patients more than 6 days overdue an INR test were contacted by letter to remind them to book an appointment.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had a record of an Albumin:Creatinine ratio test in the preceding 12 months compared with the national average of 86%, and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). Also 100% of patients aged 75 or over with a fragility fracture on or after 1 April 2012, had been treated with an appropriate bone-sparing agent compared with the national average of 81%

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. If this occurred the GP reviewed the use of that medicine and if they continued to prescribe it they outlined the reason that this was deemed necessary. This meant that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was effective in the prescribing of antibiotics and we saw evidence that their prescribing was half the national average for both Cephalosporin and Quinolones.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided a dedicated telephone number in case those patients or their carers had difficulties accessing the reception contact number to discuss with concerns with a GP.

The practice had outcomes that were comparable to other services in the area. For example, the percentage of patients aged 65 and older who had received a seasonal flu vaccination was better than CCG average for the area at 97.2%.

Effective staffing

Practice staffing included medical, nursing, physiotherapy, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses developed by the practice 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 undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All staff had an annual appraisal and the learning needs of staff were identified and training put in place to meet the learning needs. The nursing team and HCA were supported by the GPs and nurse practitioner to maintain and further develop their skills and experience. There were regular meetings to discuss performance. For example, action plans were written and put into force. Interviews with staff confirmed that the practice provided funding and training for relevant courses such as Safeguarding and the Mental Capacity Act 2005

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as those seeing patients with long-term conditions like asthma, COPD, diabetes and coronary heart disease were able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice had positive working relationships and had forged close links with other health and social care providers which included being part of a Federation, to co-ordinate care and meet patients' needs.

Good

Are services effective?

(for example, treatment is effective)

We saw various multi-disciplinary meetings were held. For example, regular palliative care meetings were held, which involved practice staff and the district and McMillan care nurses.

The practice had been used in a care taking role for GP practices in the Leicester City Clinical Commissioning Group and had recently taken on in excess of 1000 patients from a nearby practice that had closed.

The practice had joined a Federation with other practices in the CCG to work together to improve the outcomes for patients. The practice had signed up to provide a range of enhanced services. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Examples include alcohol related risk reduction scheme, extended hours access, avoiding unplanned admissions, chlamydia screening and minor surgery. The practice had systems and identified leads in place to deliver and monitor its performance against the enhanced services. We also saw completed data returns to the CCG to demonstrate the delivery of enhanced services.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice provided a dedicated telephone number in case those patients or their carers had difficulties accessing the reception contact number to discuss with concerns with a GP. We spoke with staff who told us that they found the systems in place and meetings worked well.

Information sharing

The practice used a number of computer based systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Systems were also in place for making referrals. We spoke with staff who told us that these methods of communication were easy to use.

The practice had systems to provide staff with the information they needed, clinical and non-clinical. Staff used an electronic patient record, to coordinate, document and manage patients' care. Staff were trained to use the system and spoke positively about the benefits. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also used clinical reporting systems to help co-ordinate patient care

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All staff had recently received specific training on consent and the MCA. Decisions about or on behalf of patients who lacked mental capacity to consent to what was proposed were made in the person's best interests and in line with the MCA. The GPs described the procedures they had followed where people lacked capacity to make an informed decision about their treatment

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. Staff provided us with examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.).

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia. The practice staff sign posted patients to additional services such as lifestyle management and smoking cessation clinics. There was also a wide range of information on the practice website.

The practice offered NHS Health Checks to all its patients aged 40-75

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. Practice records showed all had received a health check up in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for cervical smear uptake was 82.2%, which was higher than other practices in the same CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

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

The practice had employed from within their own budget an in house physiotherapist. This had reduced the waiting time for a course of treatment to be started. The waiting time was now two weeks with the aim that patients were able to return to work sooner.

The PRG also assist in flu clinics and had been trained to record blood pressures, height and weight measurement from the automated testing machine that was located in the waiting room and memory tests for those patients who wished it.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included results from the national GP patient survey published on 8 January 2015, 36 CQC comment cards and recent results of the friends and family test. The evidence from all these sources showed patients were satisfied with the way they were treated and that this was with compassion, dignity and respect. The national GP patient survey showed the practice was above average for its satisfaction scores on consultations with doctors and nurses. 90% had said the nurse they saw or spoke to was good at involving them in decisions about their care and 83% said the last GP they saw or spoke to was good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. The majority of the 21 comments we received were extremely positive about the service patients experienced. Staff were described as efficient, helpful and caring. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Five comments were less positive but there were no common themes to these.

We spoke with six patients in the reception and waiting areas of the practice including patients from a number of different practice population groups. The majority of the patients we spoke with were very happy with the service they received. All of the patients we spoke with told us that the GPs and the nurses were caring, patient, kind and treated them with respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 from outside

.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The layout of the surgery reception and waiting room meant that patients were able to overhear conversations at the reception desk. Staff did the best they could to prevent patients from overhearing and offered a separate room if the patient did not wish discuss matters at the desk. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

The practice liaised with other appropriate agencies and signposted patients via the website, leaflets or advertisements on the screens in the waiting room.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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. Patient feedback on the comment cards we received was extremely positive and aligned with these views. Patients spoke of the high regard they had for the staff at the practice. Nationally reported data showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey taken in September 2014 showed 73% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were in line or slightly better than results nationally.

Patient/carer support to cope emotionally with care and treatment

Discussions with staff and feedback from patients demonstrated staff were highly motivated and were driven to offer care that was kind, caring and supportive. We observed person centred interactions between staff and patients on the day of our inspection.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them and a letter of condolence was sent. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service

The practice kept a register of all patients who were carers for family members. This was backed up by the practice computer that alerted staff if a patient was also a carer. Administrative support staff we spoke to told us how they would raise a concern with the GPs if a patient who was also a carer missed an appointment or had not collected their own medicines. Staff showed a high level of awareness of the impact on carers of caring for a family member

There was information on display in the waiting room, on the practice website and in the newsletter for patients on how to access a number of support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of the local population. The majority of patients we spoke with and those who filled out CQC comment cards said they felt the practice was meeting their needs. For example, patients could access appointments face-to-face in the practice, receive a telephone call back from a clinician or be visited at home.

Where patients were known to have additional needs, such as being vulnerable, frail, or had a learning disability, this was noted on the patient's medical record. This meant the GP would already be aware of this and any additional support could be provided, for example, a longer appointment time.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patient surveys and audits.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Many of the patients registered with the practice were eastern European. As a result of this the practice had proactively recruited two Polish members of staff and produced a newsletter Polish. There were also a small Asian population in the area and the GPs speak a number of Asian languages. The practice also had access to online and telephone interpretation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was situated on the ground and first floors of the building with services for patients on both floors.

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 rooms. Accessible toilet facilities were available for all patients attending the practice including disabled and baby changing facilities.

People whose circumstances may make them vulnerable.

People were easily able to register with the practice, including those without a permanent address Homeless people were also advised about services specifically designed for them by Inclusion Healthcare Social Enterprise CIC in the city which provided high quality primary health care services for homeless people and vulnerably housed people.

Access to the service

The practice provided access with appointments available from 7am to 6:30 pm on Monday, Wednesday, Thursday and Friday. They also were open from 8am to 6:30pm on Tuesdays. Telephone access was available throughout all opening times.

Services were tailored to meet the needs of the local population and were delivered in a way to ensure flexibility and provide choice. Patients were able to book appointments either by calling into the practice, on the telephone or using the on-line system. Face to face and telephone consultations were available to suit individual needs and preferences. Home visits were also made available every day. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Home visits were made when requested to local care homes and homes for persons with learning disabilities by a named GP.

Patients confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours on weekdays were appreciated by patients who could attend before work or after school.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person (the Practice Manager) who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system displayed on the waiting room wall, in the practice newsletter and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at how complaints received by the practice in the last twelve months had been managed. The records showed the complaints had been dealt with in line with the practice policy.

Minutes of team meetings showing that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

(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 clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room.

The practice statement of purpose stated that their mission was to:

- Provide a high standard of medical care, to be committed to patient's needs, to act with integrity and complete confidentiality, to be courteous, professional, approachable, friendly and accommodating.
- Ensure safe and effective services and environment, to improve as a patient centred service through decision making and communication, to maintain motivated and skilled work teams. Through monitoring and auditing continue to improve healthcare services.
- Maintain high quality of care through continuous learning and training. To guide employees in accordance with diversity and equality and finally treat all patients and staff with dignity, respect and honesty.
- Be an efficient, academically sound and compassionate service to the sick. To promote good health practices within the community and to enable each member of the team to obtain fulfilment of these aims, free from unnecessary personal, professional or economic stress.

We spoke with five members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had variety of policies and procedures in place to control activity and these were accessible to staff on any computer inside the practice. We examined seven of those policies and procedures and most staff had completed a cover sheet to substantiate that that they had read the policy and when. All seven policies and procedures we examined had been reviewed annually and were up to date.

There was a transparent leadership structure with named members of staff in lead roles. For instance, there was a lead nurse for infection management control and a lead GP e lead for safeguarding. We spoke with five members of staff and they were all clear regarding their own roles and responsibilities. All of them told us they felt valued, well supported and knew who to go to within the practice with any issues.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a musculoskeletal Audit and Clinical Review.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as electrical safety. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

We saw that there were daily meetings of the practice manager and the senior partner to discuss any urgent issues.

The practice manager was accountable for human resource policies and procedures. We reviewed a variety of policies, for example the practice disciplinary procedures and also the induction policy, that were in place to support staff. We were shown the employees handbook that was accessible to all staff. This included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if needed.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the patient survey carried out by the PRG after the practice had received many comments about the difficulty of getting by telephone. An audit identified the problems and came up with some solutions resulting in an increase in patients using the on-line booking system to in excess of 1700 (21%). Patients were also able to cancel appointments, order repeat medication and view their summary medical records. As a result there had been a marked reduction in telephone usage during busy periods.

An emergency, dedicated telephone number was issued to patients at high risk of emergency admission.

Patient help and information sheets covering all areas of disease and health management was also published on the Fosse Medical Centre website for patient access.

Patients we spoke with were much happier with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice had a very active and well led patient reference group (PRG) which has steadily increased in size to 12 members. The group had covered the practice demographics in the following areas: Female and male patients, students, disabled, and Eastern European members. The group included members from the working and retired sectors of the population. The PRG met every quarter and with attendance from GP's and the practice manager, all meetings were minuted and available on-line and in the waiting area. The PRG produced a newsletter four times a year. Among other information in the newsletter were the figures for patients who did not attend (DNA) with a reminder that reception should be informed. The PRG also assisted at flu clinics and had been trained to record blood pressures, height and weight measurement from the automated testing machine that was located in the waiting room and memory tests for those patients who wished it. The PRG had told us that they felt much supported by the practice manager and GPs and felt able to discuss directly any issues.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to keep up their clinical development through coaching and mentoring. We examined three staff files and saw that regular annual appraisals took place and this included a personal development plan.

The practice had completed reviews of significant events and other incidents and shared the outcomes with staff at meetings to make sure the practice improved outcomes for patients