Latham House Medical Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Latham House Medical Practice on 16 April 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe and well led services. It was good for providing an effective, caring and responsive service.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice had a system for reporting incidents, near misses or concerns however evidence of learning and communication to staff was limited.
- The practice did not have a system in place to ensure an appropriate standard of cleanliness and infection control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Latham House Medical Practice achieved 99.2% of the total QOF target in 2014, which was 1.5% points above CCG Average and 5.7% above national average.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The January 2015 national patient survey showed that 80% of patients would recommend the surgery to others. 86% described the overall experience as good.
- The practice did not have a system in place to monitor the learning and development of staff.
- The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient reference group (PRG), surveys and complaints received.
- There was not a clear system in place to identify and monitor staff training.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The areas where the provider must make improvements are:

- Embed a system to ensure that staff are aware of and learn from significant events, near misses and complaints.
- Embed a system to manage, monitor and review risks to vulnerable children, young people and adults.
- Carry out actions identified from risk assessments carried out by the external company in June 2014. Put a policy in place and carry out regular water checks to reduce the risk of legionella.
- Embed a robust monitoring system for infection control to include a system of audits and risk assessments where appropriate.
- Ensure there is a clear system in place to identify and monitor staff training.

In addition the provider should

- Embed a system where risks are monitored regularly to identify any areas that need addressing and discuss at governance meetings.
- Have a system in place to ensure audit cycles have been completed.
- Provide staff with guidance on whistleblowing.
- Ensure actions taken in response to a review of prescribing data is disseminated to all staff including the registrars.
- Ensure GP's due for safeguarding training have undertaken the required updates.
- Update the recruitment policy and procedure to contain guidance for staff on the appropriate recruitment checks required prior to employment.
- Put a process in place to ensure that the fridge temperatures at the branch surgery are reset daily in line with national guidance.
- Update policies to include the name of the responsible person.
- Embed a system where themes and trends from complaints are reviewed, discussed and actions taken where appropriate.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were carried out but lessons learned were not communicated widely enough to support improvement.

The practice did not have a robust system to manage, monitor and review risks to vulnerable children, young people and adults. The practice did not have a system in place to ensure an appropriate standard of cleanliness and infection control. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. The practice did not have a clear system in place to identify and monitor staff training. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.2% of the total QOF target in 2014, which was 1.5% points above CCG average and 5.7% above national average.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they 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.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

There was a clear leadership structure and staff felt supported by management. It had a vision and a strategy but not all staff was aware of this and their responsibilities in relation to it. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Audits carried out by the practice were not all completed audit cycles. The practice had completed reviews of significant events and other incidents. We did not see any evidence that the reviews were shared with staff at meetings ensure the practice improved outcomes for patients.

The practice did not have effective systems to manage and review risks to vulnerable children, young people and adults. The practice proactively sought feedback from staff and patients, which it acted on. The patient reference group (PRG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

The practice is rated as good for the care of people with long-term conditions.

The practice had staff who were trained in lead roles in long term conditions (LTC). The lead Diabetic specialist nurse (DSN) nurse trained the local community staff to undertake more health checks on housebound patients, to ensure high quality care remained in place.

Structured annual reviews were also undertaken for people with long term conditions, e.g. Diabetes, Asthma, and COPD. We were shown data that 91% of patients with Diabetes, 75% of patients with Asthma and 92% of patients with COPD had received an annual review in the last year.

12,476 patients registered with the practice received repeat medicines and 86% had received an annual review. 5,671 patients of this patient group were on four or more medicines and 93% had received a review.

The practice had a system in place for people with LTC, vulnerable and in poor mental health who might be at more risk of emergency admissions. Patients were identified by the integrated care worker, and the practice's nurse care co-ordinator and they visited the patients in their place of residence and liaised with the wider multi-disciplinary team.

People with long term conditions

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Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

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.

The practice had a good working relationship with a midwife who held clinics every week.

Information was shared with the health visitor, and every child seen in the Minor Treatment Unit (MTU) was referred to the health visitor. We were told that communication between the practice, midwife and health visitor was effective. Unwell children were always seen on the same day. Babies and children over six months were seen by the immediate access nurse, those under six months by the GP.

Pregnant women who were ill were always seen by a GP.

Rates were relatively high for all standard childhood immunisations and specific clinics were in place for childhood immunisations. There were late appointments to accommodate working parents on both Monday and Thursday evenings. A teenage immunisation clinic was held on Monday afternoons and the appointments were well attended,

The practice ran a successful CHAT (confidential health advice for teenagers) clinic on Wednesday evenings for the last 20 years. It was a drop in service offered by nurses. It included general health advice, contraception advice, STI screening, pregnancy testing, emergency contraception and chlamydia screening. This service was well advertised in the practice and in the local schools.

Summary of findings

The practice had close links with the school nurse and two local academies. Students were directed to CHAT for further advice if needed. At least once yearly the nurses held health fairs and sexual health screening sessions. The practice website also had sexual health and screening advice.

Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and 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. 8824 patients aged between 45-54 years of age. 93% had received a blood pressure check.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

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. The practice had 143 patients on the register and 86% had received an annual review. The nurse and lead GP were specifically trained to care for these patients and to create their annual health action plan. Patients with learning disabilities were given a double appointment when they attended for a blood test.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had 328 patients on the palliative care register. 82% had received an annual review.

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

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

A lead nurse at the practice visited patients with dementia annually in their own homes, to ensure a review of all their needs was undertaken.

The practice had 251 patients for patients registered with dementia. 70% had received an annual review.

The practice had a lead GP for mental health. They had 222 patients on a mental health register. 96% had received an annual review for mental health and 97% for a general review of other long term conditions.

Annual health checks were carried out by a external mental health co-ordinator. This provision was made by the East Leicestershire and Rutland CCG. They also attended the practice to see patients on an individual basis. A psychiatrist from the community mental health team attended the practice on a weekly basis. He was also available for GP's to ask advice.

The practice had 512 patients for patients registered with a depression. 86% had received an annual review.

The practice had four doctors with specialist training in substance misuse and work with a tertiary service to provide care for this group of patients. The patients were under the shared care substance misuse scheme. This enabled them to obtain all their medical services from one location. They had 56 patients registered and 78% had received an annual review. Monthly meetings took place and all patients currently registered for this scheme were regularly discussed.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The January 2015 national GP patient survey had a 43% return rate. It showed that 80% of patients who responded would recommend the surgery to others. 86% described the overall experience as good. 85% felt the GP treated them with care and concern. This was the same as the Clinical Commissioning Group average but above the national average. In relation to nurses, 91% of patients felt they were treated with care and concern.

We spoke with 14 patients on the day of our visit. They told us staff were kind and caring. They were happy with named GP and were involved in decisions around care and treatment. Regular health checks took place and communication was good.

Patients expressed concern regarding the lack of appointments and the difficulty getting through to the surgery by phone. They told us they had to wait at least two weeks to see GP of choice. One parent told us that their two year old did not get seen on the same day.

We spoke with four members of the patient reference group (PRG). The PRG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The PRG chair told us they meet on a monthly basis but will have additional meetings as required.

They had a good rapport and worked well with the practice and were developing action plans to address issues patients had raised.

Areas for improvement

Action the service MUST take to improve

- Embed a system to ensure that staff are aware of and learn from significant events, near misses and complaints.
- Embed a system to manage, monitor and review risks to vulnerable children, young people and adults.
- Carry out actions identified from risk assessments carried out by the external company in June 2014. Put a policy in place and carry out regular water checks to reduce the risk of legionella.
- Embed a robust monitoring system for infection control to include a system of audits and risk assessments where appropriate.
- Ensure there is a clear system in place to identify and monitor staff training.

Action the service SHOULD take to improve

- Embed a system where risks are monitored regularly to identify any areas that need addressing and discuss at governance meetings.
- Have a system in place to ensure audit cycles have been completed.
- Provide staff with guidance on whistleblowing.
- Ensure actions taken in response to a review of prescribing data is disseminated to all staff including the registrars.
- Ensure GP's due for safeguarding training have undertaken the required updates.
- Update the recruitment policy and procedure to contain guidance for staff on the appropriate recruitment checks required prior to employment.
- Put a process in place to ensure that the fridge temperatures at the branch surgery are reset daily in line with national guidance.
- Update policies to include the name of the responsible person.
- Embed a system where themes and trends from complaints are reviewed, discussed and actions taken where appropriate.

Latham House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included two GP specialist advisors, two further CQC Inspectors, a GP practice manager specialist advisor, two practice nurse specialist advisors and an Expert by Experience.

Background to Latham House Medical Practice

Latham House Medical Practice provides primary medical services to a population of 35,700 registered patients in Melton Mowbray, Leicestershire. Latham House Medical Practice is one of the largest single group practices in the country. They cover a seven mile radius of Melton Mowbray and are the only GP practice in Melton Mowbray. The Practice encourages their clinicians to have specialist areas of interest and they offer patients the opportunity to be on a particular doctors list so that patients can forge long lasting relationships with the doctor of their choice. A branch surgery at Asfordby provides a local service for patients who prefer not to travel to the main surgery in Melton Mowbray.

Latham House Medical Practice has a main reception as you enter the building. There are reception areas for each of the GP suites which are well signposted and each has their own telephone line. The practice is open from 8.30am to 6.30pm. A duty doctor is on available 8am to 8.30am and 6pm to 6.30pm.

Appointments are available at various times between: 8.30 am to 5.30 pm at the main site at Melton Mowbray and between 9.00 am to 10.30 am at the Asfordby branch surgery. Extended hours appointments are also available Mondays 7.50am to 8.00am and 6.30pm to 7.00pm, Thursdays 6.30pm to 7.00pm. The practice have a nurse led minor treatment unit (MTU) which is open from 8.30 am to 6.00 pm.

The practice has separate areas for administrative and clerical staff. These included staff taking phone calls, repeat prescriptions, new patients who want to register, patients who are referred through choose and book, secretaries and coders of medical notes

At the time of our inspection the practice employed 15 GP partners, three salaried GP's, one practice manager, one finance manager, one patient services manager, one reception manager, one maintenance manager, one IT manager, 25 practice nurses, five health care assistants, one phlebotomist and 54 reception and administration staff.

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

The practice's services are commissioned by East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG). ELR CCG have full responsibility for commissioning healthcare services for residents in Blaby, Lutterworth, Market Harborough, Rutland, Melton Mowbray, Oadby and Wigston and the surrounding areas. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

Detailed findings

We inspected the following locations where regulated activities are provided:-

Latham House Medical Practice, Sage Cross Street, Melton Mowbray, Leicestershire. LE13 1NX.

Asfordby Branch Surgery, Regency Road, Asfordby, Leicestershire, LE14 3YL

GP and Nurse appointments can be booked up to two weeks in advance. Some on the day appointments are also available. The practice also have nurse led Immediate Access Clinics which provide access for patients requesting an urgent or 'same day' appointment.

The practice are a teaching practice for GP registrars and nursing graduates.

Latham House Medical Practice is part of the Primary Care Research Network (NHS National Institute for Health Research).

Latham House Medical Practice have opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided to Leicester City, Leicestershire and Rutland by Central Nottinghamshire Clinical Services.

A new urgent care service for East Leicestershire and Rutland launched 1 April 2015. It provides patients with more choice and increased access to healthcare at weekends, bank holidays and evenings. Minor injuries and illnesses will be treated locally and the service aims to reduce the time it takes patients to be seen and treated. Patients can attend one of the centres at Melton Mowbray, Oakham, Oadby or Market Harborough.

We spoke with the management team with regard to their registration certificate. There had been changes to the GP partners which was not reflected on their current certificate and did not fulfil the criteria in the CQC (Registration) Regulations 2009. After the inspection we received information that the practice have commenced the process to update their registration certificate.

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

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

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

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

We carried out an announced inspection on 16 April 2015.

We asked the practice to put out a box and comment cards in reception where patients and members of the public could share their views and experiences.

Detailed findings

We reviewed 55 comments cards. 44 out of the 55 cards completed were positive. Most felt that the quality of care was very good. They felt respected, well looked after and said staff were kind and considerate. 11 patients reported that there were issues with getting an appointment, attitude of receptionists and on three occasions medicines were missed off their repeat prescriptions. We spoke with the management team who told us they would look into the concerns raised.

On the day of the inspection we spoke with GP partners, members of the management team, nurses, reception and administration staff.

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had systems in place to identify risks and monitor the safety of patients. For example, national safety patient alerts, significant events and reported incidents as well as comments and complaints from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. 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 and recording significant events, incidents and accidents.

Themes had been identified and dates identified for discussions at practice meetings. We reviewed records of five significant events that had occurred during the last year and saw this system was followed appropriately. We saw the Significant event and Serious Untoward Incident Protocol which had been reviewed April 2015 but did not identify who the responsible person was.

A dedicated meeting for significant events was last held in January 2015 to review actions from past significant events and complaints. Further meetings had not taken place and there was no evidence that the practice had shared the finding with all relevant staff. However 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 on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. For example, in March 2015 a member of staff slipped. We saw evidence of action taken as a result.

in January 2015 a member of staff had injured their head after banging it on a shelf. The practice had taken action and removed the shelf to prevent any further harm.

The practice had a patient safety alert protocol which had been reviewed in October 2014. Three people were identified to receive National patient safety alert emails and these were then disseminated by the patient service manager. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

We saw minutes of a meeting held in January 2015 in regard to weather alerts and reference was made to their disaster continuity and recovery plan.

Reliable safety systems and processes including safeguarding

The practice did not have effective systems to manage and review risks to vulnerable children, young people and adults. The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. We found on the day of inspection that the practice did not have a robust system and were unable to tell us how many safeguarding referrals had been submitted, completed, monitored and followed up. We spoke with the lead GP who told us that they held the overall lead position but the individual GP's within the practice were responsible for ensuring that their own actions were completed, monitored and followed up. Significant event analysis we looked at highlighted that there was a delay in the practice responding to or dealing with safeguarding issues in a timely manner.

We looked at the protocols for safeguarding vulnerable adults and children, the practice had not documented who the dedicated GP was. However the dedicated GP had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles.

We were told that staff had completed safeguarding training to an appropriate level and were able to see records of safeguarding training for some staff. After the inspection we were sent the training records for all the GP's. Some GP's were due an update and the management team had contacted the provider for scheduled dates for further training. Safeguarding meetings were held on a six to eight weekly basis. They are attended by a number of GP's, nurses (practice and community), health visitor, school nurse, midwives and a management representative.

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

child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy which was available on the practice web site. (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). The practice had a policy of undertaking a DBS check on all staff including receptionists who carried out chaperone duties. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We were told that staff who carried out chaperone duties had received training and the staff records we viewed confirmed this. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We were told by the practice manager that the practice had a rolling programme to check the DBS of all staff but this was on-going and not all staff had currently been checked.

Medicines management

We checked medicines stored in the treatment rooms and seven medicine refrigerators at Latham House Medical Practice and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Each fridge had a USB date logger and was checked weekly or more often if any fridge experienced temperature problems. Vaccine fridge contents were audited weekly to check stock levels.

We were told that all staff were aware of the necessity to maintain the cold chain. Receptionists received medicine orders and immediately alerted one of the nursing team who ensured that the medicines/vaccines were dealt with as per the practice policy.

We saw the validated ice boxes for flu and home visit vaccines. These were also used for moving vaccines from one room to another in the practice. In the busy influenza season, the practice hired extra fridges for the storage of large quantity vaccines to meet the needs of the practice population.

We visited the branch surgery at Asfordby and checked medicines stored in the treatment rooms and refrigerators. We found they were stored securely and were only accessible to authorised staff. We looked at the checklist in place for checking and recording the daily temperatures of the refrigerator and found that records of temperatures had been kept but there was no indication that the temperature had been reset on a daily basis in line with requirements. We spoke with the member of staff responsible for recording temperatures and they told us they were not aware that this was necessary and only reset the temperature when the temperature recorded was outside the correct range. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times

We saw records of monthly partner meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. The information was disseminated to all partners but we did not see any evidence that the registrars within the practice received the same information to ensure they had taken the same action.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Requires improvement

Are services safe?

Cleanliness and infection control

We observed Latham House Medical Practice to be clean, tidy and well maintained. We saw that the practice allocated three hours a day for the health care assistants to undertake infection prevention and control duties to ensure that the patient areas were kept clean. There were cleaning schedules in place and cleaning records were kept.

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use.

There was an adequate supply of cleaning materials which were stored securely. We saw that the practice used a recognised coloured coded cleaning system for mops and cloths as stated in current hygiene guidance. Mop heads were changed weekly or more frequently as required. Each GP suite had one cleaner who was employed for three hours per day. The cleanliness of the practice was overseen by the maintenance manager on a daily basis.

Each clinical room had clinical waste bins which were foot operated and lined with the correct colour coded bin liners. Clinical Waste was stored in line with national guidance. All staff we spoke with were aware of the waste disposal policy and guidelines for the practice.

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

All staff received induction training about infection control specific to their role and received mandatory updates, for example, hand hygiene, PPE, handling and disposal of sharps, waste and specimen handling.

Notices about hand hygiene techniques were 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 blood and vomit spillage kits available for staff to use and guidance for staff to follow in the event of a spillage. Staff were given guidance on how to use these kits in their mandatory infection control updates.

Sharps bins were correctly assembled and labelled except for one in the minor treatment unit. We saw sharps injury policy displayed for staff in the event of a sharps injury. Full sharps bins were kept locked until disposal by an external contractor. Staff we spoke with were aware of the procedure in the event of a sharps injury.

The practice had blood and vomit spillage kits available for staff to use. Staff were given guidance on how to use these kits in their mandatory infection control updates.

An 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 including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. The policy and procedures were reviewed November 2014.

The practice had a lead nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role but we could not see any evidence that they received annual updates.

The practice had not carried out a full infection control audit since 2013 and we found that the practice policy did not make any reference to infection control audits or risk assessments. After the inspection we were sent hand washing and room audits. The room audits did not specify what had been looked at or any actions identified. National guidance states that audits must be undertaken to ensure that key policies and practices are being implemented appropriately.

We visited the branch surgery at Asfordby and found the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. However it had not been recorded that the specified weekly cleaning tasks had been carried out. Disposable curtains were in the consulting rooms and had been changed regularly. Minor surgery was performed in the treatment room at the branch surgery and we saw a detailed schedule for cleaning the room prior to use for minor surgery. However there were no cleaning records available to show that this procedure had been followed.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which

can contaminate water systems in buildings). We saw that the practice had legionella risk assessments for both Latham House Medical Practice and the Asfordby branch which were completed by an external company in June 2014. Both risk assessments identified actions that the practice need to take. We did not see any action plans, responsible person identified and timeframe for these actions to take place. At the time of the inspection the practice did not have any evidence that they had carried out regular checks of the water supply to reduce the risk of infection to staff and patients as documented in the risk assessments.

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.

We saw the practice had an inspection, calibration and replacement of equipment policy which was due to be reviewed in September 2015. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy and procedure in place that set out the standards it followed when recruiting clinical and non-clinical staff. The policy had been reviewed in January 2015 but did not contain guidance for staff on the appropriate recruitment checks required prior to employment.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were told by the practice manager that the practice had a rolling programme to check the DBS of all staff but this was ongoing and not all staff had currently been checked.

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.

The practice used locum GPs infrequently but when necessary to maintain staffing levels. They had a robust process in place to recruit locums and a comprehensive induction and guidance pack to support them.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice did not have a Health and Safety policy but had a health and safety management responsibilities procedure which had been reviewed in April 2015. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw an examples of the risk assessments, for example, electrical equipment, general office activities, new and expectant mothers and the mitigating actions that had been put in place. We did not see a risk log or any meeting minutes where risks were discussed.

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 in the minor treatment unit (MTU) which included oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed

that it was checked regularly. We checked that the pads for the automated external defibrillator and found that the paediatric pads were not within their expiry date. The practice ordered some immediately.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Hypoglycaemia is a low blood sugar. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We found a significant event analysis where a emergency had taken place in the practice and actions had been taken appropriately.

A disaster continuity and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in 2015.

The practice had carried out a fire risk assessment in April 2014 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 and evacuation drills on a yearly basis. We saw records of the last fire drill and evacuation in September 2014. Actions were identified but we did not see an action plan, person responsible to deal with actions and a timeframe. Staff had completed fire safety training and five staff members had received further training as fire marshals.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We discussed with a GP who had the overall lead for NICE guidance how information was received into the practice. They told us that each GP looked at a particular guideline for their special interest and presented information to others within the practice team at educational events. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses 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 review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Management, monitoring and improving outcomes for people

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

The practice showed us a number of clinical audits that had been undertaken in the last three years. One of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

We looked at a Vasectomy Audit from April 2014 to March 2015.The aim of the audit was to ensure that patients were satisfied with the care they had received. 133 patients had the procedure and there were only two cases where there was no record of consent being obtained. 11 questionnaires were returned by patients. 100% would recommend the service to family and friends. 91% were offered a choice of date and time of procedure and 100% of patients who completed the questionnaire had given informed written consent.

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). For example, we saw an audit regarding the prescribing of antibiotics associated with C Difficile. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records of a second audit cycle which showed how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.2% of the total QOF target in 2014, which was 1.5% points above CCG Average and 5.7% above national average

For example:

- The performance for diabetes related indicators was 95.8% which was 0.9% better than the CCG and 5.7% better than the national average.
- The performance for asthma related indicators was 100% which was 1.5% points above CCG average and 2.8% above the national average
- The performance for patients with hypertension was 100% which was 2.9 % better than the CCG average and 11.6% better than the national average.
- The performance for patients with COPD was 100% and 2.8% better than the CCG average and 4.8% better than the national average.
- The dementia diagnosis rate was 100% and was 2.3% above CCG average, and 6.6% above national average

The practice was aware of all areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement

The practice's prescribing rates were also better than national figures. There was a protocol for repeat prescribing which was November 2014 and followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The practice had 12,476 patients who received repeat medicines and 86% had received an annual review. 5,671 patients were on four or more medicines and 93% had received a review.

The practice had made use of the gold standards framework for end of life care. It had 328 patients on a palliative care register. 82% had received an annual review. We spoke with the lead GP and designated nurse for palliative care. The practice had palliative care meetings. These were internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Multi-disciplinary palliative care meetings were held monthly. They were attended by a number of GP's, nurses (practice, community and specialist) social care and a representative from the practice management team. The practice were in the process of extending the invites to the local residential and nurse home managers. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice also had general multi-disciplinary team meetings to discuss patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, for example, homeless, travellers, learning disabilities. The meetings were monthly and were attended by members of the practice team, community nurses and the patients registered doctor. Structured annual reviews were also undertaken for people with long term conditions, e.g. Diabetes, Asthma, and COPD. We were shown data that 91% of patients with Diabetes, 75% of patients with Asthma and 92% of patients with COPD had received an annual review in the last year.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. There was not a clear system in place to identify and monitor staff training. The practice manager told us they could access records of online training completed but did not have a clear system in place to record and monitor staff training. They told us they had

Good

Are services effective?

(for example, treatment is effective)

identified this as an area for improvement and had plans to implement a training matrix which would clearly show which training had been completed and monitor when further training or refresher training was due.

We noted a good skill mix among the doctors. A number of GP's had specialist interests, for example, Gynaecology, Cardiology, Rheumatology, Dermatology, Ophthalmology and minor surgery

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).

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

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 were also able to demonstrate that they had appropriate training to fulfil these roles.

The staff files we looked at contained evidence that an annual appraisal had been undertaken. Each appraisal identified learning needs and action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. Staff were encouraged to develop and take on new areas of responsibility, for example one of the practice nurses had undergone further training relating to asthma in order to expand her skills.

We spoke with the a lead GP who described an example where poor performance had been identified appropriate action had been taken to manage this in line with the practice procedures which was also included in staff contracts.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of-hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Emergency hospital admission rates for the practice were relatively low at 10.6% compared to the national average of 13.6%.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register). These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to

Good

Are services effective?

(for example, treatment is effective)

have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient,

the practice had drawn up a policy to help staff. For example, in emergency situations. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice had a 'big leaflet' which was sent out together with a letter to inform the patient of their yearly review and when to attend. The practice had 143 patients for patients registered with a learning disability. 86% had received an annual review.

The practice had 251 patients for patients registered with dementia. 70% had received an annual review and 90% had received an annual blood test. The practice had a lead GP and designated nurse for dementia. The nurse carried out home visits on the patients who were housebound. Advance care planning was completed by the patient's own GP. Referrals were made to secondary care where appropriate, for example, for a memory clinic appointment.

The practice had a lead GP for mental health and 222 patients on their register. 96% had received an annual review for mental health and 97% for a general review of other long term conditions. Annual health checks were carried out by an external mental health co-ordinator. This provision was made by the East Leicestershire and Rutland CCG. The external mental health co-ordinator also attended the practice to see patients on an individual basis. A psychiatrist from the community mental health team attended the practice on a weekly basis. He was also available for GP's to ask advice.

The practice had 512 patients for patients registered with a depression. 86% had received an annual review.

The practice had 328 patients on the palliative care register. 82% had received an annual review.

The practice offer a substance misuse service. They had 56 patients registered and 78% had received an annual review.

12,476 patients received repeat medicines and 86% had received an annual review. 5,671 patients were on four or more medicines. 93% had received a review.

8824 patients aged between 45-54 years of age. 93% had received a blood pressure check.

There was a practice protocol for consent. It provided staff with guidance on how the principles of consent could be put into practice. It provided staff with guidance on the types of consent and included the Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions)

The practice had a minor surgery protocol which included consent obtained for the procedure. The practice had done a post vasectomy audit which found that all patients who had undergone the procedure had had their consent documented.

When interviewed, staff gave 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 we spoke with demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. Each GP had their own list of patients. The preferred GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their

Good

Are services effective?

(for example, treatment is effective)

contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 66% of patients in this age group took up the offer of the health check compared to a CCG average of 47%. Patients were followed up by a GP if they had risk factors for disease identified at the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help.

For example,

- 68% of eligible patients had received an influenza vaccination.
- 96% of patients on the mental health register had received a mental health review and 70% on the dementia register had received a dementia review.
- 289 patients had had a cognitive test performed by their GP.
- 86% of patients who suffered with depression had received a review.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of patients over the age of 16 and actively offered smoking cessation advice to 96% of these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 158 patients. Similar mechanisms of identifying 'at risk' groups were used for patients with long term conditions. For example, 99% of patients with COPD, 98% of patients with diabetes, 98% of patients with coronary heart disease and 99% of patients who had had a stoke had been immunised against influenza.

The practice's performance for the cervical screening programme was 80%, which was slightly above the CCG average of 78%. After three do not attends (DNA) the practice send a letter from their GP followed by an appointment to sign a waiver if they wish to decline cytology screening. The practice carry out smear audits for each nurse every three months to ensure they continue to be competent to undertake the procedure.

Chlamydia screening is offered to all eligible patients. A reminder on the patient electronic computer system reminds the nurses to ask. 18% of eligible patients have been screened.

The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Children who do not attend are followed up by Leicester & Rutland Community Health Services.

Last year's performance was above average for the majority of immunisations where comparative data was available.

For example:

- Flu vaccination rates for the over 65s were 75% compared to a CCG average of 71%.
- Childhood immunisation rates for the vaccinations was 96% compared to the CCG average of 93%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey, a survey undertaken for the GP partners by the practice's patient reference group (PRG). The survey was undertaken in a 3 week period during November 2014 and 354 responses were received. Results were collated by the PRG. (A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the January 2015 national patient survey showed the practice was rated as good.

For example:

- 85% of patients who responded said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%. 89% said the nurse was good at listening to them compared to the CCG average of 91% and national average of 91%.
- 88% patients who responded said the GP gave them enough time compared to the CCG average of 89% and national average of 87%. 93% said the nurse gave them enough time compared to the CCG average of 93% and national average of 92%.
- 97% patients who responded said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%. 96% said they had confidence and trust in the last nurse they saw compared to the CCG average of 97% and national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 55 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. 11 comments were less positive and the common themes were getting through by phone, getting an appointment and to see a GP of choice. We also spoke with 14 patients on the day of our inspection. Most were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some also told us they had issues with appointments and the length of time for an appointment to see a GP of choice

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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 practice switchboard was located away from the reception desk and in a separate room which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This was introduced to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled, where possible, confidentiality to be maintained. Additionally, 90% said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

There was a clearly visible notice in the patient reception area and in the practice information leaflet stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The January 2015 national GP patient survey information we reviewed showed patients has responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in some areas. For example:

- 86% of patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national

Good

Are services caring?

average of 86%. 93% of respondents said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91% and national average of 90%.

- 76% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%. 84% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 85%.

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 also positive and aligned with these views.

We visited the branch surgery at Asfordby. Patients we spoke with told us that they preferred to attend the branch surgery. They said staff were wonderful, the practice was more accessible and car parking was much easier.

Patient/carer support to cope emotionally with care and treatment

The January 2015 national GP patient survey information we reviewed showed patients rated the emotional support provided by the practice below CCG and national average in this area. For example:

- 85% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice were committed to address any specific needs for carers. Information on the practice leaflet asked carers to complete a form so that they could offer help and support wherever appropriate and practicable.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG), for example, the PRG had raised the fact that accessing the practices services on the telephone needed to improve. The practice have increased the number of staff who answer the telephone but now need to increase the number of telephone lines to ensure patient calls can be answered quickly.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The practice had easy to understand information to help the practice support patients with their health needs. For example, a booklet on NHS health checks and the patient received a health check action plan which staff gave out at the end of their review.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The practice had some information leaflets translated into Polish.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as most facilities were all on one level. We saw that the waiting areas were 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 baby changing facilities. Hearing loop and information for partially sighted was available at reception.

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

Staff completed equality and diversity training. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 24 months

Access to the service

The practice was open from 8.30am to 6.30pm. A duty doctor was available 8am to 8.30am and 6pm to 6.30pm. Appointments were available at various times between 8.30 am and 5.30 pm at the main site at Melton Mowbray and between 9.00 am and 10.30 am at the Asfordby branch surgery. Extended hours appointments were also available Mondays 7.50am to 8.00am and 6.30pm to 7.00pm, Thursdays 6.30pm to 7.00pm. The practice also have a nurse led minor treatment unit (MTU) which was open from 8.30 am to 6.00 pm.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with their named GP or nurse.

Home visits were made by a named GP to those patients who needed one.

The patient survey information we reviewed showed mixed results about access to appointments and generally rated the practice as average in these areas. For example:

- 62% were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 76%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 71% described their experience of making an appointment as good compared to the CCG average of 74% and national average of 74%.
- 63% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65%.
- 61% said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 74%.

Most patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four to six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. There was a notice displayed on the wall in the waiting area for complaints to be directed to reception. The practice had the complaints forms behind the reception area. This meant they always endeavoured to resolve any verbal complaints immediately. If the practice were unable to resolve the complaint at the time the patient was given a leaflet on how to proceed to a formal complaint. Patients we spoke with were not 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 complaints received in the last 12 months and found that the majority were acknowledged within three working days. We found an apology had been given and the complaints were thoroughly investigated. Where possible the practice acknowledged receipt of complaints on the same day they were received. There was evidence of openness and transparency in their responses. There was no timeframe for the final response of the complaint however most were resolved within 28 days. We found that only three had gone over three month's time period. In these cases the practice provided constant updates and communication with the complainants to keep them informed.

The practice reviewed complaints annually. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. The practice leaflet had information on complaints and included details of NHS England, Parliamentary Health Service Ombudsman and the NHS Complaints Advocacy (POhWER).

The practice held quarterly meetings where complaints had been discussed. We could not see any evidence that information and learning had been shared with all staff within the practice.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values included in their statement of purpose. The practice stated that there purpose was to provide the best possible range of quality services for patients within a confidential and safe environment and ensure they see the right clinician for their care needs. The practice will show patients courtesy and respect at all times irrespective of ethnic origin, religious belief, personal attributes or the nature of the health problem

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 27 of these policies and procedures but did not see a completed a cover sheet to confirm that staff had read the policies and procedures and when. All 27 policies and procedures we looked at had been reviewed annually and were up to date.

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

The management team took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed and action plans were produced to maintain or improve outcomes where required.

The practice did not have effective systems to manage and review risks to vulnerable children, young people and adults. The practice were unable to tell us how many safeguarding referrals had been submitted, completed, monitored and followed up. Significant event analysis we looked at highlighted that there was a delay in the practice responding to or dealing with safeguarding issues in a timely manner.

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. However most of the audits we reviewed were not completed audit cycles.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice did not have a Health and Safety policy but had a health and safety management responsibilities procedure which had been reviewed in April 2015. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example, electrical equipment, general office activities, new and expectant mothers and the mitigating actions that had been put in place. We did not see a risk log or any meeting minutes where risks were discussed. We did not see any evidence that the practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). Risk assessments had been carried out but actions identified did not have action plans, responsible person identified and timeframe for these actions to take place. At the time

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of the inspection the practice did not have any evidence that they had carried out regular checks of the water supply to reduce the risk of infection to staff and patients as documented in the risk assessments.

The practice held regular meetings where governance issues were discussed. We looked at minutes

from these meetings and found that performance and quality had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff. We were shown the staff handbook of terms of conditions available to all staff which included sections on complaints, confidentiality, health and safety. It also included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

The practice did not have a whistleblowing policy available to staff at the time of our inspection. There was a paragraph in the staff handbook of terms and conditions but it did not provide staff with sufficient guidance.

Leadership, openness and transparency

The partners in the practice were available in the practice and staff told us that they were approachable.

The practice took part and were proactive at the Clinical Commissioning Group (CCG) locality meetings. In collaboration with other GP practice the meetings were an opportunity to discuss commissioning, liaise with local health service providers, and to ensure that primary care health needs were being met for the population in their locality.

All GP's within the practice have had a clinical peer review. At practice protected learning time (PLT) events they discuss audits, review protocol updates, controlled drugs training and Nice guidance

Over the last twelve months the nurses employed within the practice have started to undertake peer reviews.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.

Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient reference group (PRG), surveys and complaints received.

It had an active PRG which included representatives from various population groups. For example, a representative Age UK, a patient who represented the Polish Community, a member of the local Health & Wellbeing board and at least two members are official Carers. Currently there were 12 members, ages ranging from 25yrs to 75 yrs. They consisted of 4 females and 8 males. In March 2015 the PRG launched its own website. The PRG met every month. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice and PRG websites.

We spoke with four members of the PRG and they were very positive about the role they played and told us they felt engaged with the practice. (A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussions.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

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

The practice was a GP training practice. The practice had three registrars on the day of the inspection. GP Registrars are fully qualified doctors who already have experience of

Are services well-led?

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hospital medicines and gain valuable experience by being based within the practice. They work full-time in the practice for a period of four 12 or 15 months dependent upon the stage of training they were at.

The practice had completed reviews of significant events and other incidents. We did not see any evidence that the reviews were shared with staff at meetings ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and Treatment must be provided in a safe way for service users. The registered person did not have a system in place to manage and learn from significant events and near misses. Staff who were involved in incidents should receive information about them and this should be shared with others to promote learning. The registered person did not have a system in place to ensure an appropriate standard of cleanliness and infection control, for example, infection control audits and risk assessments where appropriate. The registered person did not have processes and a policy in place for legionella. Water checks were not carried out to reduce the risk of legionella. Actions from legionella risk assessments in 2014 had not been carried out. This was in breach of 12 (2) (b) (h) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found the registered person did not have effective systems and processes in place to protect vulnerable adults and children. The registered person must review the current system for safeguarding vulnerable adults and children and carers. Ensure the policy includes the responsible lead person.

This section is primarily information for the provider

Requirement notices

Ensure there is a formal process for the management, monitoring and review of risks. Have a system in place to ensure that outstanding safeguarding concerns have been followed up effectively.

This was in breach of Regulation 13 (1) (2)(3) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have a robust system to monitor the learning and development of staff employed within the practice. The practice did not have a training matrix to support the planning of training. This was in breach Regulation 18 2(a) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014)