Queens Road Surgery

Quality Report

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Date of inspection visit: 7 May 2015
Date of publication: 06/08/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Queens Road Surgery 7 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all population groups.

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. A new system was in the process of being embedded and information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was made available.
- 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.
- There was a clear leadership structure and staff felt supported by management. The practice listened to feedback from staff and patients, which it acted on.

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

Importantly the provider should :

- Implement a cold chain policy and ensure fridge temperatures are reset daily.
- Check the emergency oxygen levels and equipment at more regular intervals in line with national guidance.

Summary of findings

- Ensure there is signage on the room which contains oxygen and emergency equipment.
- Ensure the system of changes to patient's medication on the computer system being made by a GP is embedded to reduce the risk of errors.
- Create a patient participation group (PPG) by 31 March 2016 in line with contractual requirements and in order for patients and the practice to work together to improve the service and improve the quality of care patients receive.
- Implement further training for the infection control lead and also to ensure staff awareness of the about the Mental Capacity Act 2005 and consent.
- Ensure the new system for reporting and reviewing significant events is fully embedded.
- Ensure PGD's are signed by all relevant staff.
- Ensure actions identified in infection control audits and spot checks are allocated and completed.
- Update details in safeguarding policy and ensure all staff aware of safeguarding lead.
- Implement multi disciplinary meetings.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Most risks to patients were assessed. 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 National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. However some staff were not aware of the Mental Capacity Act 2005 or consent issues relevant to their role. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams although there were no formal multi disciplinary meetings.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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

Summary of findings

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 to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy which included a five year plan. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. Staff had received inductions, performance reviews and attended staff meetings and events. The practice did not have a patient participation group (PPG) in place.

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 older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and patients spoke positively about this. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Patients at high risk of emergency admissions had been identified to reduce admissions to secondary care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Structured annual reviews were undertaken to check that health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 a robust system for following up children who did not attend for immunisations.

Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours . We saw evidence of joint working with midwives and health visitors.

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 offered services that were accessible, flexible and offered continuity of care. The practice had recently introduced a website in order to promote online services as well as a wide range of health promotion and screening that reflects the needs for this age group.

Summary of findings

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 such as those with a learning disability. It had carried out annual health checks for people with a learning disability and 16 of the 25 patients of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

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). In order to support patients experiencing poor mental health,the practice held a register of patients with significant mental health problems. There were 99 patients on the register and 85% of those had a care plan in place. These were not personalised but the template was comprehensive. Similarly, there was a template care plan in place for patients with dementia. In the last year, of the patients on the mental health register 92% had received a blood pressure check and 86% of those eligible had undertaken cervical smear screening.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We reviewed 65 comments cards that had been completed and left in a CQC comments box. The

comment cards enabled patients to express their views on the care and treatment received.

The majority of comment cards reviewed were extremely positive about the care and treatment provided. Patients said they felt the practice offered a very good service and staff were polite, accommodating and caring. They said staff treated them with dignity and respect. Seven respondents commented negatively on some aspects of the appointment system but overall were still positive about the service they had received.

In January 2015 the national GP patient survey showed that 87% patients described the overall experience of the practice as good and 96% had confidence or trust in the last GP they spoke with.

The practice had commenced the Family and Friends testing (FFT) on 1 December 2014. FFT enables patients to provide feedback on the care and treatment provided by the practice. We looked at the feedback from April 2015 and found that 35 out of 39 patients would be likely or extremely likely to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Implement a cold chain policy and ensure fridge temperatures are reset daily.
- Check the emergency oxygen levels and equipment at more regular intervals in line with national guidance.
- Ensure there is signage on the room which contains oxygen and emergency equipment.
- Ensure the system of changes to patient's medication on the computer system being made by a GP is embedded to reduce the risk of errors.
- Create a patient participation group (PPG) by 31 March 2016 in line with contractual requirements and in order for patients and the practice to work together to improve the service and improve the quality of care patients receive.
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- Implement multi disciplinary meetings.

Queens Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a second CQC Inspector and a GP practice manager specialist advisor.

Background to Queens Road Surgery

Queens Road Surgery provide Primary Medical Services for approximately 2,800 patients from a surgery in Leicester City.

At the time of our inspection the practice employed two GP partners (male), one practice manager, one assistant practice manager, one Quality and Outcomes Framework (QOF) co-ordinator, one nurse, one health care assistant and two reception and administrative staff. QOF is a system used to monitor the quality of services in GP practices.

The practice manager had been promoted to the post in the summer of 2014 and had peer support from a previous practice manager who was available on a day to day basis. The practice manager told us he felt well supported.

The practice has a Primary Medical Services Contract (PMS). A PMS contract is a local contract agreed between NHS England and the practice, together with its funding arrangements.

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

Queens Road Surgery, 282 Queens Road, Leicester, LE2 3FU.

The provider described Queens Road surgery as a branch surgery of their main surgery at St Peter's Medical Centre, St Peter's Health Centre, Sparkenhoe St, Leicester. LE2 0TA. Because the provider had registered the main surgery and branch surgery as separate locations with the Care Quality Commission (CQC), we were not able to inspect them as part of the same inspection. St Peter's Medical Centre was inspected on 6 January 2015. The provider's PMS contract covered both locations and therefore some of the data referred to in this report relates to the joint practice population of Queens Road Surgery and St Peter's Medical Centre.

The practice is located within the area covered by Leicester City Clinical Commissioning Group (CCG). The CCG is responsible for commissioning services from the practice. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

Leicester City is one of the most diverse and disadvantaged urban areas in the country. Leicester has a young population. About 60% of people living in Leicester are under the age of 40 and there are fewer people aged 65 and over compared to the national average. Approximately 50% of patients are from

ethnic minorities, with nearly a third of the population being South Asian. The city has the largest Indian population of any local authority area in England, while it also has thriving communities of people originating from Somali, middle eastern, African and eastern European backgrounds.

Leicester City have some of the most deprived areas and patients have some of the worst health of anywhere in the country. Leicester has the 20th most deprived population in England and about half of patients are considered to be highly disadvantaged.

Detailed findings

Queens Road Surgery 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.

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 and some data is combined for the provider's two practices.

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 NHS Leicester City Clinical Commissioning Group (CCG), NHS England (NHSE), Public Health England (PHE), Healthwatch Leicestershire and NHS Choices.

We carried out an announced inspection on 7 May 2015.

We asked the practice to leave a box and comment cards in reception to enable patients and members of the public to share their views and experiences with us.

We reviewed 65 completed comment cards. Of these 64 were positive and described very good care given by staff who were caring, understanding and responsive, seven of which also included comments on the appointments system. One was less positive and related to ongoing treatment.

We spoke with members of staff which included a GP, a GP trainee, the practice manager, the assistant practice manager, the QOF co-ordinator, the nurse, the health care assistant and two reception and administration staff.

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

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these and could evidence a safe track record. The practice manager told us minutes of meetings were sent electronically to all members of staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents.

Staff used incident forms which they completed and sent to the practice manager. We reviewed four incidents which had been recorded since December 2013 and saw records were completed in a timely manner. The practice manager told us he had reviewed the process for recording significant events and had introduced a new system and incident forms for completion from February 2015.

As part of this new process incidents including significant events were a standing item on the practice meeting agenda and an annual meeting had been introduced to review significant events and complaints. There were some inconsistencies in the recording of significant events as the new system had not yet had time to be embedded but we saw evidence that the practice had learned from significant events and the findings were shared with relevant staff. Staff, including receptionists and administrators knew how to raise an issue for consideration at the meetings and told us they felt encouraged to do so.

The practice manager had a robust system in place to deal with safety alerts. He showed us a file in which he kept all safety alerts which had been disseminated to staff and signed by them to acknowledge they were aware of them. This process was confirmed by a member of staff we spoke with. We saw two examples of recent alerts that had been received and acted on appropriately. The practice manager told us he was responsible for national patient safety alerts (NPSA) and he checked to make sure they had been actioned by the relevant member of the practice team.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. The practice had policies in place for safeguarding children and adults. However the external contact details attached to the policy were out of date. Also the practice safeguarding lead was not identified in the policy.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. Not all staff we spoke with were aware of who these leads were.

The practice had a system in place for flagging vulnerable patients on their individual records to ensure they were offered appropriate support by staff. This included patients who were at risk of unplanned admission to hospital, at risk children, carers and the housebound.

The practice had a chaperone protocol in place. The practice had posters visible in the reception area and consulting rooms, outlining the availability of a chaperone if required by patients. A formal chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent of the procedure.

The health care assistant and two non clinical members acted as chaperones when required. They had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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

Good

Are services safe?

Medicines management

We checked medicines stored in the medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We checked medicines stored in a consulting room and found that the room was unlocked so could be accessible to anyone who attended the practice. We spoke to the management team who assured us that the room was normally locked when the doctor was not in the room.

One member of staff checked the temperature of the fridges within the practice. We looked at the refrigerator temperature records and found that they had been recorded daily. However the fridge had not be reset daily in line with national guidance to ensure they remained within specified limits. There was no cold chain policy for ensuring that medicines were kept at the required temperatures, or action to be taken in the event of a potential failure.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic treatment within the practice.

The nurse and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions but not all of them had been signed by the relevant staff . We spoke to the management team who assured us they would get the directions signed by the relevant staff. Staff we spoke with told us they had received appropriate training to administer vaccines.

There was a comprehensive system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results.

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

The practice did not hold stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed.

Cleanliness and infection control

We found that the practice was mostly clean and tidy.

Patients who completed CQC comments cards and staff we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Staff we spoke with told us infection control training was completed on line.

The practice had a lead for infection control but they had not currently undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw there were daily cleaning schedules in place. The practice carried out spot checks of the practice to ensure it was kept clean and tidy. We found that an action had been identified on a spot check but not action plan for when the action would be completed by and by whom.

The practice had carried out an audit in February 2015. Improvements had been identified for action but there was no action plan to determine when the actions would be completed by and by whom, for example, a first aid poster for sharps injuries.

Infection prevention and control was not an agenda item on any of the minutes we looked at.

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. The policy provided advice and support related to the quality of Infection prevention and control procedures.

Sharps bins were correctly assembled and labelled and the practice had a policy for needle stick injury.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Notices about hand hygiene techniques were displayed on the soap dispensers in staff and patient toilets.

Good

Are services safe?

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use. The practice had blood and vomit spillage kits available for staff to use and staff we spoke with knew where to find them and how to use it.

Queens Road Surgery had arrangements in place for the safe disposal of clinical waste and sharps such as needles and blades. We saw evidence that their disposal was arranged by a suitable external company.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and transmitted to people via the inhalation of mist droplets which contain the bacteria. This is the cause of human Legionnaires' disease. The most common sources are water tanks, hot water systems, fountains and showers).

We saw records that confirmed the practice had undertaken a legionella risk assessment and carried out regular running of the water taps in line with the policy to reduce the risk of infection to staff and patients.

Equipment

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

We saw evidence of calibration of relevant equipment, for example weighing scales, blood pressure monitoring and spirometer used for testing the air in and out of patient's lungs.

Staffing and recruitment

We looked at six staff files which 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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff to cover each other's annual leave. When necessary the practice used locum staff to cover clinical roles. There was a robust system in place for ensuring relevant checks were carried out on locums employed by the practice and a locum pack was in place to support any locum GPs.

Staff told us there were enough staff to maintain the efficient running of the practice and there were always enough staff to keep patients safe. Staffing on the day of our visit and records we saw demonstrated that actual staffing levels and skill mix were in line with the 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 annual and monthly checks of the building, the environment, medicines management, staffing and equipment. However the last electrical safety check had taken place in 2008 and the certificate was therefore out of date. Following our visit the practice manager informed us that an electrical safety check had been arranged.

The practice manager was identified as the lead for health and safety. They had a health and safety policy. In December 2014 the practice had undertaken a thorough health and safety risk assessment. Action had been identified together with person responsible and progress made. Health and Safety information was displayed in the kitchen area of the practice.

Identified risks were included on a health and safety risk log. Each risk was assessed but had not been rated. Mitigating actions were recorded to reduce and manage the risk. We saw that some risks had been discussed within practice meetings. For example, the process for taking delivery of vaccines and the importance of maintaining the cold chain had been discussed at the practice meeting held in March 2015.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support.

The practice had oxygen and equipment to maintain a patient's airway in the event of an emergency, for example, oxygen mask and airways. When we asked members of staff, they all knew the location of this equipment. Records showed that the oxygen cylinder and levels was only checked three monthly, commencing in May 2015. Guidance from the UK resuscitation council states that equipment including oxygen should be checked on a weekly basis as a minimum. There was no signage on the door where the emergency equipment was kept to identify it's location and no warning that oxygen was stored in the room.

Some emergency medicines were available in an area of the practice and some staff knew of their location. These included those for the treatment of anaphylaxis. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. The practice did not routinely hold stocks of medicines for the treatment of diabetic emergencies. They had not carried out a full risk assessment and did not have a protocol in place to manage this emergency. Processes were 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 that not all GPs carried emergency medicines in a doctor's bag. We were told that home visits were triaged by telephone. If a GP did not routinely carry emergency medicines they would ascertain if any drugs were required and which ones. They would then take the appropriate drugs dependent on the patient's condition.

A business continuity and disaster 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 practice had carried out a fire risk assessment that included actions required to maintain fire safety. The practice had identified that they did not have any fire extinguishers. Following our visit we raised this with the practice manager who advised us that fire extinguishers were being installed later in the month. We saw records which showed that the practice had completed fire drills. Records showed that staff were up to date with fire training.

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 saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The practice manager was responsible for circulating new guidance and there were guidance pages contained within the practice's computer system to support clinical staff. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse and healthcare assistant supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice manager showed us data from the local CCG of the practice's performance for antibiotic prescribing, and a two cycle clinical audit of the practice's prescribing which was comparable to similar practices.

GPs we spoke with used national standards for the referral of suspected cancers and patients were referred and seen within two weeks.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice showed us two completed clinical audit cycles which had been undertaken in the last 18 months. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, in the prescribing of antibiotics.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 60% of patients with long term conditions had an annual medication review. This practice was not an outlier for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was a research active practice and accredited by the National Institute for Health Research. They had participated in primary care based research including the glucose lowering in non-diabetic hyperglycaemia trial (GLINT) study on diabetes, cannabinoid and ertugliflozin.

The practice had a palliative care register but had not implemented the gold standards framework for end of life care. The practice did not have formal multi disciplinary meetings to discuss the care and support needs of patients and their families.

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.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as fire safety, infection control, health and safety, safeguarding children and adults and basic life support. GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had recently undertaken an annual appraisal, other than a member of staff who was leaving the practice. These appraisals identified learning needs from which action plans were documented. For example in one member of staff's recent appraisal the need for training in ear syringing had been identified. The practice manager also told us that a number of staff had requested IT training so it was going to be incorporated in the forthcoming protected learning time (PLT) afternoon at the practice. Our interviews with staff confirmed that the practice was supportive in providing training and funding for relevant courses. 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 for support. We received positive feedback from the trainees 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. Those with extended roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. We looked at the process the practice had in place for 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 an effective protocol and process in place to deal with incoming communications. Relevant staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well .The GP reviewed documents and results and was responsible for the action required. However when the practice received hospital discharge letters, these were reviewed by the GP, but if a change to a patient's medication was required, a non clinical member of staff was tasked with changing the medication on the computer system which could have resulted in an error being made. Following our inspection the practice manager informed us that a new process had been introduced to ensure all new medication was added on the computer under the GPs direct supervision.

The practice worked with members of the multidisciplinary team (MDT), such as the midwife, Macmillan nurses and the district nurses. Formal MDT meetings did not take place but all members of the team communicated informally. Staff we spoke with felt they had good relationships with the extended team and information was shared and the system worked well.

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. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and there was a system in place whereby a member of staff was responsible for checking referrals every month to ensure that the patient had attended their appointment.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational during 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Good

Are services effective?

(for example, treatment is effective)

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, and were positive about the system's safety and ease of use. 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 not all staff were aware of the Mental Capacity Act 2005 (MCA) and their duties in fulfilling it. The GPs we spoke with told us they had received training in the MCA and understood the key parts of the legislation. However when we spoke with the health care assistant we found they did not have an awareness of the MCA or consent. They were not aware of how a patient's best interests were taken into account if a patient did not have capacity to make a decision, neither did they have an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Other than for GP's we saw no evidence of any training for staff being undertaken about the Mental Capacity Act or consent.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The 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 contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. The practice carried out 176 health checks in the previous year which equated to 26% of patients in this age group taking up the offer of the health check. The practice manager showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice's performance for cervical smear uptake was 72% which was below the average for the CCG area, which was 79%.There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The practice manager told us the uptake was lower than average due to some patients reluctance to have a smear test based on cultural beliefs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above 90% and higher than the average for the CCG. There was an effective process for following up non-attenders.

Older people were supported by the practice by having a named GP if they were over 75. The practice also participated in the unplanned admissions enhanced service which had identified the 2% of patients at highest risk of an unplanned admission to hospital. This equated to 90 patients, all of whom had care plans in place in order to decrease the risk of admission to hospital.

The practice had also signed up to the Better Care Fund initiative which was led by the CCG. The purpose of this was to bring together health and social care services to integrate care and facilitate fewer patients being treated in hospital and more remaining independent in their own homes. The practice had identified a further 8% of patients at the highest risk of the need of intervention and had put in place 258 care plans for these patients, which was above their local target of 246 care plans.

The practice held a dementia register which included 66 patients. Of these patients 68% had been reviewed in the last year.

Structured annual reviews took place for patients with various long term conditions, with 60% of these patients having received a medication review in the last year. Of the diabetics on the practice register 91.5% had received an annual foot check. We also saw that health promotion advice had been documented in patient notes.

We saw that young people were signposted towards a sexual health clinic which was housed in the same building as the provider's other surgery. We found that the practice had a low chlamydia testing rate and we were told this was largely due to some patients ethnicity which meant they preferred to go to the sexual health clinic than visit their own GP for this test.

Good

Are services effective?

(for example, treatment is effective)

The practice held a register of patients with a learning disability. In the last year 64% patients on the register had received an annual review.

In order to support patients experiencing poor mental health, the practice held a register of patients with significant mental health problems. There were 99 patients on the register and 85% of those had a care plan in place.

These were not personalised but the template was comprehensive. Similarly, there was a template care plan in place for patients with dementia. In the last year, of the patients on the mental health register 92% had received a blood pressure check and 86% of those eligible had undertaken cervical smear screening.

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 and a patient survey undertaken by the practice in June 2014.The practice's own survey had been conducted over a two week period and had only received 16 responses. The practice had not extended it in order to allow more patients to participate. We also looked at the data collected from the NHS Friends and Family test (FFT) from April 2015. The

FFT is an opportunity for patients to provide feedback on the care and treatment they receive with a view to improving services. The evidence from 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 87% rated their overall experience as good, compared to 81 % in July 2014. Similarly 83% found receptionists were helpful, which again was an improvement on the July 2014 data. Both these scores were above the CCG average. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. The FFT showed that 35 out of 39 patients were likely or extremely likely to recommend the practice to friends and family.

The practice was also above average for its satisfaction scores on consultations with doctors and nurses. 91% of practice respondents said the GP was good at listening to them and 82% of respondents felt nurses were good at listening. In response to the question of whether they were given enough time by clinicians, 85% of respondents felt GPs did and 88% said nurses were good at giving them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 65 completed cards and the majority were extremely positive about the care and treatment provided. Patients said they felt the practice offered a very good service and staff were polite, accommodating and caring. They said staff treated them with dignity and respect. Seven respondents commented negatively on some aspects of the appointment system but overall were still positive about the service they had received.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy screens 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 was shielded by glass partitions which helped keep patient information private.

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

There was a clearly visible notice in the patient reception area 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 responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, 80% felt the GP was good at explaining treatment and results and 84% felt that nurses were good at explaining treatment and results. The results from the January 2015 national GP patient survey showed that 79% of patients said they were sufficiently involved in making decisions about their care which was above the CCG average. In relation to nursing staff, 73% of respondents felt that nurses involved them sufficiently in decision making. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

The practice manager told us that translation services were available locally for patients who did not have English as a first language if necessary. We did not see any notices in the reception areas informing patents this service was available.

We were also told that a number of languages were spoken by staff and this was used to support patients when necessary.

Patient/carer support to cope emotionally with care and treatment

The January 2015 national GP survey information we reviewed showed patients were very positive about the emotional support provided by the practice and rated it well in this area. For example, 96% of patients had confidence and trust in the last GP they saw and 97% of respondents had confidence and trust in the nurse. However only 77% of patients said the GP they saw or spoke to treated them with care and concern and 86% of patients who responded felt they were treated with care and concern by the nurses.

Comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and went out of their way to provide support when required.

Notices in the patient waiting room and on the TV screen also told patients how to access a number of support groups and organisations. The practice had recently set up a website and planned to include signposting information on this in due course. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us that if families had suffered a bereavement, their usual GP contacted them if they felt it was appropriate in order to arrange an appointment or offer support. The practice manager showed us a letter they sent to bereaved families which gave contact details for bereavement support. However this information was only relevant for patients who had died in hospital. The practice manager told us he would review the information.

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 with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of locality meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

Tackling inequity and promoting equality

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

On the day of the inspection we looked at the appointment system at the practice. We found they were consistent and had enough appointments to meet the needs of the patients registered with the practice. Patients could book appointments a week in advance and same day appointments were also available.

The practice had a population with a high percentage of patients whose first language was not English. They catered for this by the use of multilingual staff and staff told us they could use translation services if necessary. Staff and patients told us that a family member was often used to aid communication if appropriate.

The practice was situated on the ground and first floor of the building. All services for patients were on the ground floor. There was no lift access to the first floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8.30 am to 6.30 pm on weekdays. The practice closed for lunch between 2pm and 3pm but the phone lines remained open. The practice provided extended opening hours every evening until 7pm.

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 online. 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, although it was not available yet on the practice website.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. The practice had registered patients in 14 different care homes. Home visits were made by a GP to patients in the care homes, housebound patients or other patients whose condition necessitated a home visit.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one carer we spoke with told us how the GP always saw their parents on the same day if necessary and always offered to phone them back.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. However the complaints procedure information which was available to patients contradicted the information within the practice complaints policy. Following our inspection the practice manager provided us with an amended policy and procedure which were factually correct. The practice manager was the designated responsible person who handled all complaints in the practice, overseen by a lead GP partner.

Information about the complaints system was displayed in the reception area of the practice.

We looked at the practices record of complaints received in the last 12 months. We reviewed four complaints and found

Good

Are services responsive to people's needs?

(for example, to feedback?)

that all had been responded to appropriately and in a timely manner. The practice manager told us they had recently introduced an annual complaints meeting where complaints were summarised and discussed and themes or trends identified if possible. Following the meeting the learning from the complaints was disseminated to staff via email. They told us that complaints would also be discussed as they arose at regular practice meetings but this had not yet been implemented.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. The practice had a five year plan which included the recruitment of a further GP, expansion in order to implement a minor illness service, minor surgery, advanced diabetic care and heart failure clinics. The practice manager had responded positively to issues raised at our inspection of the provider's other practice in January 2015 and implemented a number of new systems and processes.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on computers within the practice. We looked at 14 of these policies and procedures. All the policies and procedures we looked at had been reviewed annually. However some were not up to date, for example the safeguarding protocol did not name the lead for safeguarding and the external contact details were out of date. The practice manager told us he would update the relevant policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and the senior partner was the lead for safeguarding. However some members of staff were not clear who the lead was for some areas. We spoke with six 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 practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed that it had a score of 96.6%.We saw that QOF data was regularly discussed and the practice employed a QOF coordinator who worked with the GPs, nurse and other staff to maximise performance. This included QOF priorities for each member of staff with monthly updates on progress.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a range of potential issues, slips, trips and falls, legionella, COSHH and chaperone. Risk assessments had been carried out where risks were identified but no action plans had been produced and implemented.

Leadership, openness and transparency

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

The practice had in place a number of human resource policies and procedures. We reviewed a number of policies, for example, staff leave policy, a blame free culture policy and the induction policy which were all in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality, harassment, sickness and bullying at work.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, NHS Friends and Family test (FFT) and complaints received).

The practice's scores in the national GP patient survey had improved overall from July 2014 to January 2015 with 72 % of respondents saying they would recommend the practice in January 2015 compared to 64% in July 2014. The results from the FFT from April 2015 showed that 35 out of 39 patients would be likely or extremely likely to recommend the practice.

The practice did not have a patient participation group (PPG) in place. PPG's are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients received. It was part of the practice's five year plan to establish a PPG, but no timescale was stated. However from April 2015 it is a contractual obligation for practices to have a PPG.

The practice had gathered feedback from staff through staff meetings 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.

The practice had a whistleblowing policy in place, however it did not contain details of outside agencies. Staff we

Are services well-led?

Good

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

spoke with were aware of how to raise concerns internally but were unsure who to raise concerns with externally. We raised this with the practice manager who provided us with an amended policy following our visit, which included details of external agencies. Whistleblowing is the process by which staff can raise concerns they may have about the practice and the conduct of other members of staff. This enabled concerns raised to be investigated and acted on to help safeguard patients from potentially unsafe or inappropriate care.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training.

We looked at six staff files and saw that the practice manager had recently introduced a new appraisal system which included personal development plans for the staff. Staff told us that the practice was very supportive of training.

The practice was a GP training practice and provided GP training for Foundation year two doctors from the Leicester deanery of Health Education England. GP's we spoke with told us the foundation doctors have full support from the practice and all consultations were reviewed by a GP to ensure patient safety. We spoke with a trainee GP who felt supported and well supervised.