

Dr S M Arolker and Partners

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.

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Summary of findings

Overall summary

Dr Arolker and partners provides primary medical services for a local population of approximately 15,000 patients. A branch surgery is also provided at The Manor Medical Centre and the practice population is split between the two sites. We did not inspect the Manor Medical Centre branch surgery as part of this inspection.

We spoke with nine patients and reviewed fifteen completed comment cards. These had been completed by patients before the inspection and were used to gather information about the experiences of patients who used the service. We spoke with one local care home to find out what their views of the practice were. On the day of inspection we spoke with the chair of the patient participation group (PPG), three GPs and other staff including the practice manager from Parker Drive Medical Centre and the practice manager from the Manor Medical Centre, a practice nurse, health care assistant and administration staff. We observed how staff interacted with patients.

As part of the planning of this inspection, we looked at the data provided by the local Clinical Commissioning Group (CCG). During the inspection we looked at procedures and systems used and all of this information helped us to identify whether the practice was safe, effective, caring, responsive to people's needs and well-led.

We noted that the practice serves predominantly a working age population. However we found that the practice responded to the needs of older people; people with long term conditions; mothers, babies, children and young people; the working age population; people in vulnerable circumstances; and, people who were experiencing poor mental health.

We found that although some systems were in place to ensure patients were safe, medication management systems were not all robust. There were no checks in place to ensure medication in GP's bags was within its expiry date and available for use. Records to demonstrate that 'cold chain' had been maintained for travel vaccinations transported to the branch surgery were not available.

The inspection found that the practice was in breach of the regulations relating to:

Management of medicines

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Although there were systems in place to ensure patients received a safe service these were not always robust. There was no documentation in place to demonstrate that checks had been undertaken on medication contained in GP's bags for use in an emergency when visiting patients at their home address. We identified that there were no records to demonstrate that the cold chain was maintained when transporting travel vaccines to the branch surgery. One of the fridges used to store medication was not locked when not in use.

Systems were in place to share the learning from any incidents or complaints received at practice meetings. However, we were told that not all staff were involved in these meetings on a regular basis.

There were plans in place to ensure the practice could still operate in the event of a major incident.

Staff received appropriate training in infection control and the practice was regularly cleaned. Cleaning spot checks and infection control audits helped to ensure that infection prevention and control guidance was adhered to.

Are services effective?

The service was effective. There was evidence of clinical audits undertaken to improve outcomes for patients. We found that the practice had joint working arrangements with other health care professionals and services.

A system was in place to check ongoing professional registration for all clinical staff. Records were kept to ensure that staff were up to date with continuing professional development (CPD). Opportunities were available for staff to undertake professional development in addition to mandatory training.

Staff were appropriately vetted for their role and they had the skills and training opportunities, including safeguarding and basic life support skills, to ensure they could care for patients safely.

Are services caring?

The majority of patients that we spoke with were complimentary about the service they received from the GPs and practice nurses. Patients said that they were treated with dignity and respect. We observed staff speaking with patients in a friendly, kind and caring manner.

Summary of findings

Translation services were available to people whose first language was not English. The practice's website could be translated into 80 different languages.

Are services responsive to people's needs?

The practice was accessible to patients and had systems in place that ensured patients with urgent needs were seen with minimal delay. People told us that they found it difficult to get routine appointments to see a GP but for urgent appointments they were seen on the day that they telephoned. There were a number of ways in which a patient could make an appointment at the practice, including using the internet, by telephone or in person. Home visits were available for patients who were not able to attend the surgery and telephone consultations were also offered where appropriate.

Complaints received had been investigated. The complaints policy was available on the practice's website and could be translated into 80 different languages. The practice's complaint policy contained information about where a patient could complain to if they remained dissatisfied with the response from the practice.

This practice was rated amongst the worst for the results of three questions asked in the 2013 national patient survey. These responses related to the proportion of patients who would recommend their GP surgery, the percentage of patients rating their experience of making an appointment as good or very good and the percentage of patients rating their practice as good or very good. We found that the service was aware of the poor results and had conducted their own in-house practice survey which covered these areas. We were told that the PPG were happy with the results of the in-house survey and therefore no further action was taken as a result of the national GP survey.

Are services well-led?

Staff spoke of an open and supportive culture with visible management who were open to suggestions for improvement. They said they felt comfortable to raise and discuss any issues with the practice manager. We were also told that the practice was supportive of staff development. Training and professional development was encouraged.

Leadership roles for the day to day running of the practice were shared between partners and other staff. Policies and procedures clearly recorded the leadership roles and responsibilities.

Summary of findings

The PPG meet on a regular basis. We were told that the practice was supportive of patient views and listened to suggestions made by the PPG. The results of satisfaction surveys were made available on the provider's website and in a folder in the waiting room.

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

Not all areas of the practice were accessible for all patients but people with mobility difficulties could see a GP or a nurse in a ground floor room. Parking at the practice was limited but there was a dedicated parking space for people with disabilities. If patients were unable to attend the practice because they were housebound they would be seen at home.

Older people who had moved in to care home accommodation retained their GP if that was their choice.

People with long-term conditions

The practice employed clinical staff with specialist interests and training in various long term conditions such as diabetes, asthma and COPD (chronic obstructive pulmonary disease). In house clinics were held at the practice by these nurses to meet the needs of people with long term conditions. Recall systems ensure those people with long term conditions were regularly monitored.

Mothers, babies, children and young people

The practice had appropriate arrangements in place to ensure the needs of mothers, babies, children and young people were met. Child vaccination and family planning services were offered. Cervical screening was undertaken by the practice nurse.

Information leaflets in the waiting room and the provider's website gave useful information and signposted patients to specific services which met the needs of mothers, babies and young people.

The working-age population and those recently retired

The practice had appropriate arrangements in place to ensure the needs of working age people (and those recently retired) were met. Access to the service could be made by telephone, in person or online. The practice was open on alternate Saturdays and had some evening opening until 6.30pm so that people who worked had access to the service.

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

People were able to telephone the practice and speak with a GP for a telephone consultation. People could gain access to written information online in different language formats if their first language was not English. An interpreting service was also available.

Summary of findings

The practice ensured that health checks for patients with a learning disability were carried out.

People experiencing poor mental health

GPs were aware of referral processes for people to access specialist mental health care if they needed it. A GP at the practice met on a weekly basis with a member of staff from the IAPT team (Improving Access to Psychological Therapies).

Summary of findings

What people who use the service say

We spoke with nine patients who used the service in person and we received fifteen comment cards; the majority of patients that we spoke with on the day of our inspection told us they were very happy with the standards of care received at the practice. Similarly, all of the comments recorded on the comment cards were positive about the GPs and nurses and the care received. People had commented that GPs were caring and compassionate. Many of the patients that we spoke with had been registered with the practice for a long time. The main concern raised related to the difficulty in making an appointment. We were told that routine appointments can be booked up to four weeks in advance.

We also spoke with the chair of the practice's patient participation group (PPG). The PPG is a way in which

patients and GP practices can work together to improve the quality of the service. The PPG meet on a quarterly basis and the minutes from each meeting were available on the practice's website and in a folder in the waiting room. The PPG has been operational since August 2011. We were told that the practice was receptive to feedback from the PPG. Patients who provided feedback to the PPG were, overall, positive and very happy with the service provided.

A patient survey was undertaken in November 2013 and the results were published on the practice website. Both positive and negative comments were recorded on surveys that we saw.

Areas for improvement

Action the service **MUST** take to improve

Medication management systems must be robust to ensure that medication is available for use as needed and is within its use by date. Records must be available to demonstrate maintenance of the 'cold chain' for vaccination storage and transportation. Vaccination fridges must be locked when not in use.

A legionella risk assessment must be undertaken to identify the risk of legionella bacteria in water systems.

Carpets in clinic areas must be replaced with seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant flooring.

Action the service **SHOULD** take to improve

Regular team meetings should take place involving all members of staff working at the practice.

A log of safety alerts should be kept and made available to all staff.

Plans for future development of the service should be recorded.

Dr S M Arolker and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of two CQC Inspectors, a GP and an NHS practice manager.

Background to Dr S M Arolker and Partners

Dr S M Arolker and partners, in the Leicester Clinical Commissioning Group (CCG) area, provides a range of primary medical services to approximately 15,000 patients from a surgery in an older, converted building. There are currently six GP partners at the practice. The service is provided at 122 Parker Drive Medical Centre in Leicester and at the Manor Medical Centre branch surgery in Thurmaston. Patients may be seen at either location. We did not inspect the Manor Medical Centre as part of this inspection.

Dr S M Arolker is registered to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury. This is the first inspection of the regulated activities carried out at this practice.

The practice opening hours were Monday, Tuesday, Wednesday and Friday 8.00am to 6.30pm, Thursday 8.00am to 1.00pm. Thursday afternoon service is provided by Manor Medical Centre (branch surgery) for all registered patients from both sites to access. Saturdays the practice provides access to the service from 8.00am to 1.00pm alternating weeks at Parker Drive and Manor Medical Centre for all registered patients from both sites to access. The practice was closed at all other times and Leicester City

Clinical Commissioning Group is responsible for commissioning the out-of-hours service to ensure that patients could seek medical advice and attention, if necessary when the surgery was closed.

The practice serves predominantly a working age population.

Why we carried out this inspection

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

We spoke with nine patients who used the service. We also spoke with one care home covered by the practice. We looked at a range of documents that were made available to us relating to the service.

We sent CQC comment cards to the practice in advance of our inspection to obtain views from patients about the service. We received fifteen completed comment cards.

We looked at the practice's policies, procedures and some audits.

We observed how people were being responded to and talked with a member of the patient participation group (PPG). The PPG are a group of patients who work together with the practice staff to represent the interests and views of patients so as to improve the service provided to them.

Detailed findings

How we carried out this inspection

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

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

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

- Vulnerable older people (over 75s)
- People with long term conditions

- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the service and asked other organisations to share their information about the service.

We carried out an announced visit on 16 July 2014 between 9am and 5pm.

During our visit we spoke with a range of staff, including general practitioners (GPs), and the practice manager, nurses and other clinical and administrative staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Safe track record

Quality monitoring systems were in place. These helped to identify areas for improvement and identify and manage risk. Responsibilities for specific areas such as infection control, health and safety, significant events, management of incidents and safeguarding were shared between clinical staff and the practice manager.

Staff were aware of the whistle blowing procedure and said that they were encouraged to discuss issues or concerns. Staff spoke of a supportive, open culture within the organisation. We saw that safety issues were reported.

We discussed the National Patient Safety Alerts with staff. We were told that staff received this information via email. Staff were not aware of a log of safety alerts which could be used for future reference.

Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. A significant event could be either a positive or negative event which is important or unusual and provides an opportunity to identify an area for learning or improvement. Significant events could relate to clinical, organisation or communication issues, for example coping with a staffing crisis, complaints or compliments received by the practice, breaches of confidentiality or a sudden unexpected death or hospitalisation. A significant event could be an event or omission arising during clinical care and causing physical or psychological injury to a patient. We saw evidence that significant events were reported and investigated. Incidents were clearly described along with details of any actions taken. We spoke with three GPs and discussed incidents. We were told that key learning points were identified following the completion of any investigation and these were shared appropriately with staff to ensure the practice continued to be a 'learning organisation'. A significant event audit was completed.

Sharing learning from incidents with all staff is important as it helps to ensure actions are implemented to minimise the risk of reoccurrence. We were advised that sharing the learning from incidents took place at regular practice meetings. However staff we spoke with told us that there were usually three practice meetings a year for all staff. Clinical staff meetings were held more frequently but there were no regular administration staff meetings. The practice

nurse told us that practice meetings were held regularly and as and when something happened. We saw minutes of practice meetings which recorded the discussions held regarding incidents, medication errors and complaints. Learning from incidents was used to try to improve the service patients received. We were told that 'counselling meetings' were held with staff where poor practice was identified and the disciplinary procedure would be implemented if necessary.

Reliable safe systems and processes

The practice had a patient dignity and a chaperone policy. A chaperone can help to provide some protection to patients and clinicians during sensitive examinations. Staff had undertaken chaperone training and the availability of the chaperone service was promoted within the practice and on the provider's website to make patients aware that they could request a chaperone if they wished to. One female patient that we spoke with during our inspection told us that they had been offered a chaperone when they needed to have an intimate examination undertaken by a male GP.

Records showed that staff at the practice had recently received training in safeguarding. Staff were able to complete training at protected learning events or via e-learning on the computer. A training matrix records when staff completed training and when update training was due. The practice had a named lead GP and a separate deputy lead for both adult and child safeguarding. Staff were therefore aware of the person to speak to if they had any safeguarding concerns. Safeguarding policies and procedures produced by Leicester CCG were available to each member of staff on their computer system. This provided support for staff in recognising what abuse might look like and what to do if they suspected abuse might be occurring. Staff that we spoke with confirmed they had been trained in safeguarding. They were able to tell us about the safeguarding policy and showed us the laminated notices displayed in the office and GPs rooms which gave adult and child safeguarding contact details, including out of hours contacts.

Monitoring safety and responding to risk

We discussed staffing levels with the practice manager. We were told that staff worked between 122 Parker Drive and the branch surgery at The Manor Medical Centre. Annual leave was co-ordinated between the two sites to ensure adequate staffing levels were maintained.

Are services safe?

Staff at the practice were appropriately skilled and qualified for their role. Every member of staff undertook specified statutory training in addition to role specific training to ensure they could undertake their duties competently. The practice manager monitored training to ensure that staff received up-date training as required.

We saw evidence of the various risk assessments undertaken. A fire safety risk assessment was completed by an external company. Systems were in place to manage health and safety. We saw that the practice had a health and safety policy with a lead for health and safety identified and risk assessments and policies regarding COSHH (Control of substances hazardous to health).

Medical alerts from central authorities; for example warnings about a drug were disseminated to all clinicians promptly and were discussed at clinical meetings. The minutes of meetings seen confirmed this.

The emergency equipment was located in the treatment room. The Practice had a defibrillator, which is a machine used to give an electric shock to a patient if their heart has stopped, in order to attempt to restart their heart. We saw that oxygen was kept on the premises, with masks for both adults and children. A pulse oximeter (a machine used to check the level of oxygen in the patient's blood) was also available. We checked the provider's range of emergency drugs. Each drug was stored correctly and was within their expiry date. We were told, and records confirmed, that the emergency equipment and drugs were checked on a weekly basis. We saw the provider's guidelines for how to deal with an allergic reaction. These guidelines were last reviewed in June 2013 and were up to date.

Staff told us and we saw records to confirm that they received training in basic life support so that they would know what to do in an emergency. Staff told us that they received basic life support training every year. Staff spoken with knew where to find the emergency equipment if needed and were aware of the emergency procedure to follow. This helps to ensure patients in urgent need are appropriately attended to with minimal delay.

Medicines management

The practice must improve the way they manage medicines.

We noted that there were two clinical fridges. We saw that one of these fridges was located in the staff room and the other in the treatment room. Fridge temperatures were

monitored on a daily basis and the temperature was recorded in a log book. We saw that temperatures were maintained at the correct range. Although both fridges were lockable, only the fridge in the treatment room was kept locked when not in use. The fridge in the staff room was kept unlocked. The fridge should be kept locked to prevent an unauthorised person gaining access to its contents.

We checked the contents of both fridges, which contained immunisations and various other medications, and checked the expiry dates of a sample of these medications. We found each medication was within their expiry date. A member of staff explained the systems in place for stock management. This helped to ensure that the older stock was always used before the newer stock and that medicines were reordered when stock was low. This minimised the risk of patients receiving out of date medicines.

Medicines were held by each GP in their bags for home visiting. We were told that the GPs' bags were checked by the GP. There was no system in place for checking the medication in the GP's bags to ensure that the medication available was within its use by date.

We were told that all childhood and travel vaccines were delivered to the service. Some of the travel vaccines were then transported to the branch surgery. Systems in place regarding the transport of these vaccines were not robust and did not clearly demonstrate that the 'cold chain' had been maintained. The 'cold chain' refers to the process used to maintain optimal conditions, such as maintaining the correct temperature and protection from light, during the transport, storage, and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the patient.

Cleanliness and infection control

We saw that various infection control policies were available. We saw that there was a named infection control lead who undertook infection control audits. These audits included an inspection of all rooms and equipment used. Records seen confirmed that staff had completed practical training regarding hand washing technique. A hand hygiene audit was completed recently and we saw a hand hygiene policy. Staff spoken with said that they received regular infection control and hand hygiene training.

Are services safe?

We found that the practice was clean and tidy. In the clinical rooms we inspected we saw that staff had access to personal protective equipment such as gloves and aprons. However, we did notice that the treatment room had carpet. This made it difficult to clean because contaminated liquids and fluids could be absorbed into the carpet making it a risk for cross contamination. The flooring in clinical areas should be seamless and smooth, slip-resistant, easily cleaned and appropriately wear-resistant and the carpet must therefore be replaced. We were told that there was a plan to replace flooring in the clinic room.

We saw that hand gel was available in the foyer for patient use. This helped to reduce the risk of cross infection for patients at the practice.

Effective cleaning schedules were in place and we saw that spot checks were undertaken to ensure cleaning tasks were completed to the required standard.

Appropriate arrangements were in place for the management, storage and collection of clinical waste.

The practice manager told us that there were no unused water outlets at the practice. We were shown records to demonstrate that hot and cold water temperatures were monitored in line with legionella testing. However, we were told that there had been no risk assessment undertaken to consider the risks from legionella that may affect the staff or patients.

Staffing and recruitment

The practice had a stable and experienced workforce. Many of the staff had worked at the practice for a number of years. Due to increased demand for services a phlebotomist had recently been employed to undertake routine blood tests. A further practice nurse had also been employed. The workforce included twelve administration/reception staff, five data clerks, eight GP partners, one permanent locum, two practice managers, five practice nurses, two health care assistants and a phlebotomist. The health care assistant conducted NHS health checks. This helps to reduce some of the demand for GP time.

There were measures in place to maintain adequate staffing levels at all times to ensure patient needs were met. Staff worked between 122 Parker Drive and the branch surgery at The Manor Medical Centre. Annual leave was co-ordinated between the two sites.

We discussed staff recruitment with the practice manager and looked at the recruitment records for the two recently recruited members of staff. We saw that recruitment processes for new staff were robust. The staff recruitment files that we saw contained two references, application forms and information regarding previous working history. We saw evidence that criminal record checks (CRB) had been completed for all staff. Recruitment processes in place helped to ensure that staff had the necessary qualifications, skills and experience for the role to which they were employed and that they were of good character.

Regular supervision and appraisal sessions provide an opportunity for staff to discuss their performance, any learning needs and other issues relating to their work so that any issues could be managed as appropriate for the benefit of patients. Staff told us that they did not receive formal supervision sessions. The practice manager said that where poor practice or incidents were identified, 'counselling sessions' were held. These were used to learn lessons and improve practice. We saw evidence that staff received appraisals to discuss their performance and any learning needs. We saw records to demonstrate that appraisals had taken place in 2010, 2012 and 2014.

Dealing with Emergencies

There were robust plans in place to deal with emergencies that might interrupt the smooth running of the service. We saw a Service Continuity Plan which was dated December 2013. This document included information about how the Practice would respond to emergencies, such as fire, computer and utility failures, flooding, infectious disease outbreak and major casualty incident. We saw contact telephone numbers for the relevant services along with staff contact numbers and details. As part of the Service Continuity Plan, the provider's branch surgery was recorded as alternative premises for use should the main surgery be affected by incident. There was a 'buddy' arrangement with another local GP provider, in which their premises could be utilised. We saw a flow-chart which contained information for the closure of the Practice in an emergency. The document was available in printed copy and also available on the provider's intranet system. We were told that this document was reviewed and updated on an annual basis.

Equipment

We discussed equipment with the practice nurse. We were told that staff had all of the equipment that they needed to

Are services safe?

be able to perform their job role. We were told that equipment was maintained and was in good working order. We saw that electrical equipment had been PAT tested (portable appliance test) to ensure that it was safe to use. Equipment which needed calibration had been checked to ensure it was working effectively.

We saw that emergency medical equipment such as defibrillator and emergency oxygen were available and were checked on a regular basis to ensure that they were in good working order and ready for use in an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

We spoke with the practice manager about how they implemented best practice. We were told about the best practice guidance that the service followed; the GPs and nurses worked to guidance from the National Institute for Health and Care Excellence (NICE). We saw records to demonstrate that primary care interventions had been adopted at the service. We were told that best practice was discussed at clinical meetings.

We saw information displayed about the Mental Capacity Act. Staff spoken with had an awareness of the Mental Capacity Act and its implications regarding providing information and consent.

Management, monitoring and improving outcomes for people

We discussed the methods used in which to monitor and improve outcomes for people who use the service. We were told about the clinical audits that took place. The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included 'anticoagulation in atrial fibrillation' which was undertaken in light of new guidance. Atrial fibrillation is the most common heart rhythm disorder. The clinical audit reviews the use of anticoagulants for the treatment of atrial fibrillation, (anticoagulation describes a treatment that prevents blood from clotting). A review of prescriptions was also undertaken to look at savings and efficiencies.

During the inspection we spoke with nine patients and we received fifteen comment cards about the service. People were generally happy with the service provided from GPs and practice nurses. Some of the patients that we spoke with raised concerns about the difficulty of getting an appointment and others were concerned about waiting times.

We looked at some of the performance information available about the practice. This included the Quality and Outcomes Framework (QOF) and General Practice Outcomes Standards (GPOS). QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients. GPOS are a set of standards developed by clinicians to improve quality. We were told that the practice was a high QOF achiever this year and

were only 30 points below the maximum target level. A post QOF audit had been conducted to look at the areas that could improve patient outcomes and appropriate steps had been taken to achieve this.

The practice has a lower than average percentage of uptake of influenza vaccinations compared to local and national averages. Vulnerable groups such as those with long term conditions such as asthma and COPD are written to remind them to make an appointment for a flu vaccination. If they do not make an appointment they are sent a reminder letter to try and encourage them to attend the surgery. Clinicians are aware of the poor uptake of influenza vaccinations and discussions have been held to identify how they may get a better outcome next winter.

Effective staffing, equipment and facilities

Staff discussed the training and development opportunities made available to them. Records showed that staff were appropriately skilled and qualified for their role. Staff received on-going training and development and undertook specified statutory training in addition to role specific training to ensure they could undertake their duties competently. The practice manager monitored training to ensure that staff received up-date training as required. A training matrix had been developed to record all training undertaken and planned. The practice manager kept a spread sheet for mandatory training such as cardiopulmonary resuscitation (CPR), safeguarding children and adults. We were told that staff undertook fire safety training as online learning and two of the staff were fire wardens. Staff told us that they received protected learning time each year. Those staff that we spoke with said that they had all of the training needed to be able to do their job effectively and said that the practice manager was proactive regarding staff training. We were told that the CCG had an online learning management system which all staff could log in to access training such as safeguarding, infection control, chaperone and customer care. Arrangements were in place to ensure that clinical staff were revalidated in accordance with their professional registration. We discussed continuing professional development (CPD) with a practice nurse. We were told that staff were responsible for ensuring their CPD was up to date. However the practice nurse told us that they sent information to nursing staff about courses that they could attend to ensure their CPD was up to date.

Are services effective?

(for example, treatment is effective)

We saw that an appraisal system was in place. Staff we spoke with told us that they received regular appraisals. Staff commented that the appraisal process gave them the opportunity to discuss working practices and training and also to make any suggestions for change.

Working with other services

The practice held multi-disciplinary meetings in which the GPs, practice nurse and the practice manager met with a MacMillan nurse, community matron, mental health therapists and district nurses. Discussions were held about patients who are at risk of abuse, or those with complex and palliative care needs. The minutes of these meetings were available for all attendees to refer to. A system of risk stratification was used to monitor these patients. Risk stratification is a process of medical decision making which helps GPs to manage people's health. Information from health records is used to identify the relative risk of possible deterioration in health. This then identifies the need for preventive intervention which enables the clinical team to help patients get early care and treatment where it is needed.

The practice manager advised us that the GPs would inform the out-of-hours service if patients were likely to need care when the surgery was closed. Sharing information with the out-of-hours GP services is important as it helps to ensure patients receive a good continuation of care.

Health, promotion and prevention

We saw from the practice website that nursing staff provided various health promotion and prevention services. These included NHS health checks, dietary advice, weight control, smoking cessation and immunisation clinics. Health promotion is important because it supports patients to take responsibility for their own health and can help prevent illness in the future. We were told that the practice was well engaged with the NHS Health check programme and had a very good record in carrying these out. Patient education around use of services, OOH and emergency services, improving their own health and lifestyle choices was promoted by the clinicians.

We saw that the practice had a selection of information for patients in the reception and foyer relating to the promotion of good health and the prevention of ill-health. Leaflets and posters which included, for example, information about cancer, diabetes, medication, and planning pregnancy. This helped to ensure that patients had access to enough information to help them to understand risks to their health.

New patients to the practice were offered basic health checks with the nurse or GP depending on need. GPs also undertook medicine reviews to review medication need and minimise medication related problems.

The practice offered child vaccination clinics which were held during weekdays and vaccinations could be booked on alternate Saturday mornings when the practice was open.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw that the reception desk was located in the waiting area with seating close to the desk. Whilst in the waiting area we observed one person having a conversation with reception staff at the side of the reception desk, which was located away from the main waiting area but which was in a thoroughfare. A notice on the reception desk asked patients to respect other patient's confidentiality by standing back from the conversation that was taking place. This helped to reduce the potential for personal information being overheard. We heard staff speaking to patients in a professional and courteous manner, respectfully and helpfully.

The practice had a patient dignity and a chaperone policy. A chaperone can help to provide some protection to patients and clinicians during sensitive examinations. Staff had undertaken chaperone training so that they could act as a chaperone when female patients required intimate examinations by male GPs.

The practice worked closely with the palliative care team as patients approached the end of their life. We discussed bereavement support with the practice manager. We were told that if a patient had been bereaved, they would be provided with information about CRUSE. This is a charitable organisation that provides support to people after the death of someone close to them. In addition to this, referrals to a specialist mental health team were made if there was a clinical need to do so.

We asked the practice manager and a GP if the practice kept a register of patients with caring responsibilities. We saw that the provider's website requested people who were supporting a patient to notify a receptionist. The website suggests that this information would be added to the notes of the person that they are caring for so that the practice

could contact them quickly in an emergency. However following our discussions there was a lack of clarity about how carers were identified and if necessary flagged on the computer system.

We received fifteen comment cards that had been completed by patients prior to our inspection. Fourteen of the responses were positive. People referred to GPs by name and reported examples of compassion and professionalism.

Involvement in decisions and consent

We saw the consent policy which had recently been reviewed. We were told about, and shown, a consent form that was printed from the computer for a patient to sign if they were consenting to a minor surgical procedure. The practice nurse and health care assistant were knowledgeable about the procedures in place for obtaining consent. It was explained that patients gave implied consent for having their blood taken. For example, a patient may give implied consent by complying with the proposed examination or treatment, such as rolling up their sleeve to have their blood taken. Verbal consent was obtained for immunisations. We saw information displayed about the Mental Capacity Act 2005 (legislation that gives a framework for staff to use to assess whether patients can make decisions about the care and treatment they receive. The provider's website records that the practice may require the patient's consent for certain treatments or procedures. Patients are informed that they have the right to withdraw their consent at any time.

Patients we spoke with told us that the GP always listened to what they had to say, we were told that where necessary people were involved in discussions about their care and treatment.

A translation and interpretation service was available to support patients whose first language is not English. The provider's website can translate all information into 80 different languages. Some staff at the practice were multi-lingual and could help patients who only speak Gujarati, Punjabi or Hindi.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Car Parking was observed to be limited; however we saw one disabled parking space. There was a ramp leading into the building with a handrail. The main entrance door was automatic. A sign was prominently displayed stating that guide dogs were permitted within the premises.

We noted that the reception desk was at a fixed height, which would make it difficult for a patient in a wheelchair, or of restricted height, to speak with the reception staff. There were a number of consulting rooms within the premises located on the first floor. These were accessed by using a staircase (which had a suitable handrail). There was no lift available between the ground and first floor. We were told that if a patient was not able to use the stairs, they would be seen in one of the downstairs consulting rooms, or alternatively at the provider's second surgery (if the patient had transport to get there). Patients we spoke with on the day of our inspection confirmed this.

The practice website provided information to patients about the clinics and services provided by the practice and other local healthcare services. An internationally recognised translation service was available on the website so that all information could be translated into eighty different languages. We were told about the translation and interpreting services available if required and staff told us that they had used the services of a sign language service in the past. The website also contained links to information and support for specific patient groups such as carers, and provided information about self-management of minor illness for working age patients to avoid the need for them to attend the practice if it was not needed.

The practice had arrangements for managing patients with chronic conditions such as asthma, diabetes and heart disease. Patients were invited for regular reviews of their condition which were carried out by the GPs and trained nurses. One of the patients we spoke with told us that they had a chronic health condition and that they felt supported and well looked after by the practice nurses. Regular reviews of patients' health conditions helped to ensure any changes in their condition could be identified and managed promptly.

Test results, medication reviews and other important information was recorded on the computer system. Staff were aware of their roles and responsibilities for ensuring information was up to date. Referrals to other health care providers were made by the GPs via standardised forms.

We spoke with the deputy manager of one care home (for older people) whose patients were registered at the practice. We were told that GPs from the practice visited the home to see patients. GPs sat with staff and discussed those patients with complex needs and assisted the staff at the care home to complete records. We were told that the GPs always treated the patients with respect.

Access to the service

We saw that information about the surgery opening hours, as well as the out of hours 111, service, was displayed on the front door.

A computerised appointment check-in system was available in the reception and we noted that the system offered the facility for check-in to be completed in a number of different languages including, for example, English, Hindi and Gujarati.

New patients were asked to complete a new patient registration pack. This included information about past medical history, repeat prescriptions and consent for the summary care record to be shared. New patients were provided with a copy of the practice brochure. This included information about the staff, including GPs, appointment times, booking an appointment repeat prescriptions and how to complain about the practice. We also saw a list of useful contact numbers, such as the local hospitals.

An information monitor displayed information about the surgery, the out of hours service and SystmOne. SystmOne is a clinical computer system used in primary care. A selection of posters were displayed in the waiting room which included, for example, information about the Open Mind Service, needing a wheelchair, making comments and suggestions, complaints, going abroad and the Practice Charter. Patient information leaflets were available which included, for example, information about cancer, diabetes, medication, and the use of personal information.

We discussed SystmOne and the process for booking appointments with the practice manager. The practice had been using SystmOne for approximately five years. Online (internet based) appointment bookings were now

Are services responsive to people's needs?

(for example, to feedback?)

available. Online repeat prescription ordering was also now available. This enabled patients to collect the prescription from the practice or from a chemist of the patient's choice, providing there was a pre-existing agreement for this service with the chemist.

A computerised appointment check-in system was available in the reception and we noted that the system offered the facility for check-in to be completed in a number of different languages including, for example, English, Hindi and Gujarati. The provider's website could be translated into different languages to accommodate those people whose first language was not English therefore ensuring they had access to information about the GP practice. We were told that translators and sign language services had been used to support people access the service who did not speak English or who had hearing difficulties. The practice manager informed us that the practice had multi-lingual staff to help patients who only speak Gujarati, Punjabi or Hindi. This helped to ensure that patients were able to communicate their health needs and access health care services at the practice.

We discussed the practice's policy on 'walk-in appointments' with the practice manager. We were told that if a patient of the practice walks into the surgery requesting to see a GP, the patient will be asked to sit and wait, but will be seen by the first available GP. On the day of our inspection we spoke with a patient who had a 'sit and wait' appointment. The patient told us that they attended the practice at 10.50am and they were seen by the GP at 11.30am.

People we spoke with said that they could book up to four weeks in advance for routine appointments but if they booked in advance they were usually able to see the GP of their choice. All of the patients who were asked about 'urgent' appointments said that if they needed an urgent appointment they were seen on the day that they telephoned.

The practice manager told us that they offer a telephone triage service; if a patient needed advice from the GP or nurse they could call the practice to request this. The GP would then speak with the patient and consult with them over the telephone. An appointment was given on the day if required. The provider's website also gives details of the triage service and appointment systems.

Meeting People's Needs

There were systems in place to review the needs of patients who needed end of life care. A palliative care register was kept and the gold standards framework code was recorded on patient records. The Gold Standards Framework is (GSF) is a framework to improve the supportive/ palliative care of patients nearing the end of their life. We were told that gold standards meetings were held. Meetings are held with the district nurse, diabetic specialist, community nurse, mental health nurse, community health and social care nurse. Information can be passed on to the out of hours (OOH) care provider and staff told us that they worked closely with the OOH provider.

A GP described the arrangements in place for clinical message handling, liaison with out of hours providers and secondary care. The processes in place helped to ensure that essential information about patients was shared with their consent to relevant providers and agencies at the earliest opportunity. Procedures were in place to cover message handling in the event of unplanned absences. This meant that staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid inappropriate hospital admissions.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. We saw that patients were given information guiding them how to complain. A complaints poster was on display in the waiting room along with a flow chart of the complaints procedure which was provided in English, Hindi and Gujarati. The practice leaflet and the provider's website gave complaint information as appropriate.

We discussed complaints with the practice manager and a member of reception staff. We looked at complaints information available. We found that staff were aware of the action to take if a complaint was made. We were told that people who made a complaint were invited in to the practice to discuss their complaints further. The provider's website records the complaints policy and informs people that they can arrange a meeting at the practice if they wish.

Information for patients regarding complaints, mentions the use of advocacy and Independent Mental Capacity

Are services responsive to people's needs?

(for example, to feedback?)

Advocate (IMCA), and also provides details of external agencies that a complainant can contact, including NHS England, Healthwatch and the Parliamentary and Health Service Ombudsman. Contact details for these external agencies are provided in the practice leaflet and on the provider's website. Reception staff also confirmed that they had these contact details which could be given to people if required whilst they were at the practice.

We were told that complaints received were reviewed every six months. A summary of the complaints received was recorded. The practice manager said that they looked to see if there was any evidence of an emerging trend. We were advised that discussions and learning from complaints took place at practice meetings. We looked at the minutes of the last meeting. We saw that eight members of practice staff including the GPs attended the meeting. Discussions held included the type of complaint, nature of complaint, outcome, and changes/improvements to be made. We saw clear recording of the discussions and lessons learnt.

We reviewed two complaints. We saw that complaints had been responded to in line with the practice's complaints procedure. A meeting was convened with one of the complainants. We saw that letters sent to complainants provided details about the Parliamentary and Health Service Ombudsman and Healthwatch Leicester, who could be contacted if the complainant was unhappy with the outcome.

The practice has an active patient participation group (PPG) who meet on a quarterly basis. We met with the chair of the PPG who told us that the practice listened to feedback and took action where possible. The PPG had been involved in the development of a satisfaction survey and the results of the survey had been discussed at PPG meetings.

Are services well-led?

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

Our findings

Leadership and culture

The practice consisted of six GP partners including a senior partner. Staff we spoke with said that the management style was open and honest. Staff reported that management were supportive. We were told that although staff received regular appraisals they were able to raise issues or concerns at any time.

The collaborative culture of working between clinicians in the practice and community colleagues such as district nursing, health visitors and hospice care was discussed. GPs spoken with felt that this was a positive feature of this surgery.

We were told that the clinical team met to share experience, discuss clinical and organisational matters and reflect on their performance. This included looking at their planning and management system used to monitor performance against strategic goals (the balanced scorecard) and identifying areas for action and acting on these. Medicines management is also reviewed to find ways of reducing prescribing costs whilst retaining quality.

Leadership roles for the day to day running of the practice were shared between the partners and other staff. There were named leads for areas such as safeguarding, infection control and complaints. This ensured staff were clear of their responsibilities and who they should go to for support.

Governance arrangements

Staff spoken with were aware of governance issues. We were told that the information governance (IG) toolkit was completed for the year 2013/14. The IG toolkit enabled the practice to measure their compliance against the law and central guidance to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction. This helps to demonstrate that the practice can maintain the confidentiality and security of personal information. The provider's self assessment score was 92%, which gives them a 'satisfactory' rating. Members of the public are able to view the provider's IG toolkit assessments.

Staff had access to a range of policies and procedures to support them in their role and which informed clinical practice. The policies that we looked at had been reviewed recently and were all up to date. Certain staff had been

identified as leads for various areas such as safeguarding, health and safety and infection control. Staff spoken with were aware of the 'lead person' and said that they were able to obtain support and guidance from these people if required.

Systems to monitor and improve quality and improvement

We saw that regular clinical audits took place; examples of clinical audits include 'anticoagulation in atrial fibrillation'. Atrial fibrillation is the most common heart rhythm disorder. The clinical audit reviews the use of anticoagulants for the treatment of atrial fibrillation, (anticoagulation describes a treatment that prevents blood from clotting). The prescription of more expensive medicines and learning outcomes were shared during regular practice meetings.

Patient experience and involvement

We met with the chairperson of the Patient Participation Group (PPG). A PPG is a way for patients and GP practices to work together to improve services and to promote health and improved quality of care. The PPG meet every three months and is generally attended by 10 to 14 people. We were told that PPG members were sent an email requesting agenda items for the meeting. When the minutes of previous meetings had been agreed they were made available on the provider's website, in the patient handbook which was available in the waiting room and reception staff also had a copy. We saw that there was a board in the waiting area which was dedicated to PPG information; people were able to make comments or leave suggestions.

We were informed that one of the main problems identified by the PPG was access within the practice for patients who were disabled, although we were told that staff went out of their way to overcome these barriers and arrangements are made for patients to be seen in a downstairs consulting room. Additionally, we were told that car parking outside the practice was very limited. It was acknowledged that within the current premises there was little that could be done to resolve these issues.

We saw that there was a suggestions box in the waiting area. This enabled patients to share their views of the practice or make comments or suggestions.

Are services well-led?

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

Management lead through learning & improvement

The members of staff we spoke with told us that they worked well together as a team. We were told about the systems in place to manage staff wellbeing. Open discussions with staff occurred as needed and management looked at the tasks that staff had to complete to make sure that staff weren't overloaded. Staff were supported by review of workloads and regular discussions with them. Staff we spoke with confirmed that management were approachable and helpful.

We saw records that confirmed accidents and incidents were reviewed to identify and monitor any trends. Minutes of clinical meetings showed that learning from incidents took place.

Identification and management of risk

A Service Continuity Plan was in place and included information about how the practice would respond to emergencies, such as fire, computer failures, utility failures, flooding, infectious disease outbreak and major casualty incident. We saw that relevant information was contained within the document including contact telephone numbers and details of the branch and other local surgery that would be used in case of emergency.

The practice had identified the need for expansion to alternative premises due to the increasing demand on services. We were told that plans for the future were discussed but nothing was documented. The GPs we spoke with had identified the risks to the service and had a future vision but had not formally recorded this information. There was therefore no documentary evidence to demonstrate that action was being taken.

We discussed health and safety risks with the practice manager. We were shown some completed risk assessments such as fire safety and control of substances hazardous to health. We saw that health and safety posters were displayed which gave guidance to staff. We saw records which demonstrated that fire and electrical equipment was tested and maintained on a regular basis. The practice manager was monitoring water temperatures and confirmed that the taps in all water outlets were flushed out on regular basis. However, the service had not had a legionella risk assessment undertaken. A competent person should undertake this risk assessment to identify the risk of potential exposure to legionella bacteria from the water system.

Older people

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

Our findings

Not all areas of the practice were accessible for all patients. People with mobility difficulties would be able to see a GP in a ground floor room and special arrangements would be made to ensure these people could see a nurse on the ground floor if required. Parking at the practice is limited but there is a dedicated parking space for people with disabilities. There is no vertical lift to gain access to the upper floors in the building.

If patients were unable to attend the practice because they were housebound they would be seen at home. This helped to ensure that patients received the care and treatment they needed.

Older people who had moved in to care home accommodation retained their GP if this was their choice. We spoke with the deputy manager of one care home (for older people) whose patients were registered at the practice and they told us the practice staff were very responsive to their patients' needs in an urgent situation. They told us the GPs would review people with complex needs or care plans and would support care home staff in difficult situations.

People with long term conditions

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

Our findings

Patients with long term conditions were kept under review. The practice employs clinical staff with specialist interests and training in various long term conditions such as diabetes, asthma and COPD (chronic obstructive pulmonary disease). We were told that two practice nurses were trained in Spirometry. These nurses give support to patients and help plan their pathway of care. Spirometry is the measuring of breath to assess lung function.

An in house diabetic clinic is run at the practice by specialist nurses. We were told about the various other clinics which are held regarding long term conditions. This helped to ensure that any changes in the patient's condition could be addressed at the earliest opportunity.

A recall system was in place for those people with long term conditions to ensure their health needs were regularly monitored. Those people who hadn't seen a GP or a nurse for a specified period of time were reminded to make an appointment.

Mothers, babies, children and young people

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

Our findings

The practice offered child vaccination and family planning services. Child vaccination clinics were held during weekdays and vaccinations could be booked on alternate Saturday mornings when the practice was open. This helped accommodate working parents who would be unable to attend the practice during normal working hours.

Information leaflets in the waiting room and entrance foyer gave useful information and signposted patients to specific services which met the needs of mothers, babies and young people. The provider's website also contained useful contact information for local services and information about childhood ailments such as, for example, chickenpox and mumps.

Working age people (and those recently retired)

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

Our findings

The practice provided a service that supported patients who worked or had other commitments, to access the surgery. This was provided Monday, Tuesday, Wednesday and Friday when the surgery opened at 8am and closed at 6.30pm and Thursday between the hours of 8.00am. to 1.00pm. Thursday afternoon service is provided by Manor Medical Centre (branch surgery) for all registered patients from both sites to access. Saturdays the practice provides access to the service from 8.00am to 1.00pm alternating weeks. A practice nurse and GPs were available during the Saturday morning surgery.

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

The practice was well engaged with the NHS Health check programme and records seen confirmed that the practice had a very good record in carrying these out.

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

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

Our findings

Although there were no specific services for vulnerable groups of patients such as homeless or, travellers the practice advised us they were receptive to all patients to access health care with them. We were told that people from travelling communities had in the past registered as a temporary patient.

A learning disability audit was conducted. The audit included obtaining information about when the person last had a physical examination, obtaining any history from their carer and discussions regarding any services that need to be set up. We were told that the GP or advanced nurse practitioner would see people in their own home if required and longer appointments are available on alternate Saturdays.

Patients were able to telephone the practice and speak with a GP for a telephone consultation. If necessary an

appointment would be made at the practice or the GP or the advanced nurse practitioner would conduct a home visit. This helps to ensure that those people who were not able to attend the practice had access to health services.

Patients could gain access to written information online in different language formats if their first language was not English. The practice has multi-lingual staff to help patients who only speak Gujarati, Punjabi or Hindi. This helped patients to communicate their health needs and access health care services at the practice.

Immunisations for patients within this population group were actively promoted by the practice. This included immunisations for influenza although we were told that the practice has a lower than average uptake of influenza vaccination compared to local and national averages. Plans are in place to access hard to reach groups.

People experiencing poor mental health

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

Our findings

GPs were aware of referral processes for people to access specialist mental health care if they needed it. A GP at the practice meets on a weekly basis with a member of staff from the IAPT team (Improving Access to Psychological

Therapies). This helped to ensure that people who may be suffering from poor mental health have access to the services they require. IAPT is an NHS programme rolling out services across England, offering interventions for people with depression and anxiety disorders.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	People who used services were not protected against the risks associated with the unsafe use and management of medicines. Evidence was not available to demonstrate that the medicines in GPs bags were checked on a regular basis to ensure they were available and within their use by date. Not all vaccines were securely stored in locked medicine fridges. Evidence was not available to demonstrate that the cold chain had been maintained during the transportation and storage of vaccines.