

Melbourne Road Health Centre - R Kapur

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

The practice provides GP services to approximately 3000 patients in the centre of Leicester city from Melbourne Road Health Centre, Melbourne Road, Leicester. The premises is an older three storey building. The practice provides a range of primary medical services which includes family planning and minor surgery.

This was an announced inspection, which focused on whether the care and treatment of patients was: safe, effective, caring, responsive and well led. We spoke with six patients and two representatives of the patient reference group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. We reviewed written and verbal feedback from patients and observed how staff interacted with patients. The majority of the feedback about patients' care and treatment was positive.

We reviewed Information from Leicester City clinical commission group (CCG) and Public Health England.

We found the practice understood the local patient population and provided flexible and responsive services to meet their needs. Patients told us they found the service accessible and were involved in making decisions about their care and treatment.

Staff we spoke with told us they were well supported by the GPs and practice manager and that they found them open and approachable. We saw that there were systems in place to safeguard vulnerable adults and children from abuse.

We found 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.

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?

Improvements were required to ensure the practice is safe.

The practice was equipped to deal with medical emergencies, staff understood emergency procedures and had been trained to respond appropriately.

Staff were able to identify potential abuse of vulnerable adults and children and there was a system in place to respond to concerns.

There were contingency plans in place to manage foreseeable emergencies which could disrupt the smooth running of the practice.

Recruitment processes protected patients from the risk of recruitment of unsuitable or unskilled staff.

When incidents occurred which affected patient safety and required investigation this was not always done promptly and the incidents were not always reviewed. As a result there was a possibility that necessary changes may not have been implemented.

The practice did not have systems in place to ensure that risks relating to the environment in which care was delivered had been assessed.

Are services effective?

The practice was effective.

The practice had suitably qualified staff who had the necessary skills mix to provide a good standard of care and treatment. Staff were supported to consolidate and develop their knowledge and used national guidance to promote best practice in the care they delivered.

The practice communicated effectively with other services which supported co-ordinated care for patients. Patients were provided with information, advice and support to maintain their health or make positive changes to it.

Are services caring?

The practice was caring.

Patients told us they were treated with respect and understanding by professional staff who listened to them and took the time to explain their options to them.

Summary of findings

Measures were in place to protect people's dignity during examinations and patient confidentiality was respected.

Patients told us that they were provided with sufficient information and involved in the choices about their treatment.

Are services responsive to people's needs?

The service was responsive to people's needs.

Patients told us that they were able to make appointments when they wanted one and the practice was open at times convenient to them. The most recent patient survey carried out by the practice reiterated this view.

There was an interpreter available at every practice nurse clinic and the majority of staff spoke the most commonly used languages of their patient population.

The practice had an established patient participation group (PPG) which worked with management at the practice to represent the views of patients. The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

The practice had a complaints policy but there was insufficient information available, in suitable formats, about the complaints procedure to enable patients to raise a complaint.

Are services well-led?

The service was well-led.

There was an open and supportive management system. The practice had clear lines of responsibility and accountability and staff understood their roles.

Staff felt well supported and confident to raise issues which were responded to. Staff meetings were held to discuss and review issues.

Patient feedback was sought and acted upon and the practice management met regularly with the patient participation group with the purpose of improving the service.

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

Each patient over the age of 75 was assigned a named, accountable GP who had overall responsibility for the care and support of the individual patient.

GP appointments were offered on the same day and GPs would carry out home visits for those older people who were housebound, frail or too ill to attend an appointment at the practice.

Flu vaccinations were available to older people in the autumn and the practice nurse told us that if patients were unable to attend the practice for their vaccination they would organise a home visit.

The practice had advanced care planning in place for older patients with three or more long term conditions. Advanced care planning is planning ahead as much as possible in order to ensure timely access to safe, effective care and continuity in its delivery to meet the patient's needs.

People with long-term conditions

Patients we spoke with told us that they felt their long term conditions were dealt with well. They said that GPs were effective at monitoring and identifying problems with their existing condition. Patients said they felt involved in the care they received. Records showed that staff worked effectively with other agencies to ensure people had the care and treatment which was planned in line with their needs. We saw evidence of regular multi disciplinary meetings with a Macmillan nurse regarding cancer patients.

The practice had a high prevalence of patients with diabetes. There was a lead GP for diabetes and the practice nurse was undertaking further specialised training in this area.

Staff we spoke with told us that patients with long term conditions were monitored by means of an annual review with the practice nurse and blood tests every six or 12 months dependent upon their condition. A medication review was also carried out by a GP every six months or sooner if required.

Mothers, babies, children and young people

Parents we spoke with were very happy with the care their families received. They told us they had no difficulty in obtaining appointments for their children.

Summary of findings

Antenatal care for support through pregnancy was accessed through midwives who worked with the practice. Midwives held sessions at the practice once a week. There was also postnatal services for new mothers.

Appropriate systems were in place to support prompt referral of safeguarding issues relating to children. There were baby and childhood immunisation programmes available.

Family planning information and services was available.

The working-age population and those recently retired

The practice was safe, effective, caring and responsive for working age people and those recently retired.

The practice had an appointment system which enabled patients of working age to get an appointment when they needed one. On the day appointments, telephone consultations and on line appointment booking was available. Extended opening hours were provided until 6.30pm on some weekdays, and 3pm on Saturdays and bank holidays for people whose work commitments made it difficult to attend a weekday appointment.

Information was widely available at the practice about healthy lifestyles and prevention of illness. NHS health checks were available to working age people.

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

The practice had a safeguarding vulnerable adults policy in place and a nominated safeguarding lead. Staff we spoke with were aware of how to identify and raise any concerns.

There was a GP practice in Leicester city which had been commissioned to provide GP services specifically for homeless and vulnerably housed patients and the practice referred patients to the service.

People who were staying locally for a short time were able to register with the practice as a temporary patient.

Patients with a learning disability were regularly monitored including medication reviews. The practice had a high number of patients who did not speak English and staff were aware of how to access language interpretation services.

A number of staff spoke other languages and an interpreter was available at every practice nurse clinic as the practice nurse only spoke English.

Summary of findings

People experiencing poor mental health

The practice worked with local mental health services.

Staff had received training in and were aware of the requirements of the Mental Capacity Act (2005).

There was a mental health clinic held at the practice on a fortnightly basis which GPs could refer patients to. This was run by another provider.

Same day appointments were available for patients experiencing poor mental health.

Blood tests were carried out on an annual basis and medication reviews were carried out frequently by a GP unless the patient's medication was being managed in secondary care. In that situation incoming letters from the secondary care provider would be reviewed and medication updated accordingly.

Summary of findings

What people who use the service say

Melbourne Road Health Centre had carried out a patient survey of 121 patients in February 2014. This showed that 68.6% of patients described their overall experience of the GP surgery as very good and 27.3% as fairly good. In comparison the national GP NHS patient survey regarding the practice which was carried out in 2012 – 2013, showed an overall patient experience rating of 82%, which was below the national average of 87%.

Patients we spoke with on the day of our visit told us they were happy with the care they received at the practice. We received 32 comment cards on the day of our inspection. Most of the comments were positive and told us that the staff were kind, caring and compassionate.

We met with two members of the patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service.

The PPG members told us they had worked with the practice to reduce the number of people who did not attend appointments (DNA) and this had been successful.

Areas for improvement

Action the service **SHOULD** take to improve

The practice should have in place appropriate risk assessments relating to health and safety. The risk assessments should include an appropriate fire and legionella risk assessment, obtaining relevant professional advice where necessary.

The practice should ensure that all significant events are recorded in a timely manner and that they are reviewed and necessary actions documented and implemented.

Records of fridge temperatures should include minimum and maximum temperatures in line with national guidance.

The practice should have information available to patients regarding the complaints procedure and in formats appropriate to the patient population.

The practice should have a system in place to monitor the dissemination of, and actions taken, following the receipt of safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA), in order to manage risks to the safety of patients in line with their own policy.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

Due to the fact that for the majority of patients English was not their first language and the practice nurse only spoke English, there was an interpreter available at every scheduled practice nurse clinic.

The practice was open on Saturdays and bank holidays until 3pm six days per week and bank holidays to improve access for patients and reduce the impact on accident and emergency departments.

Melbourne Road Health Centre - R Kapur

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a GP, a GP practice manager, another CQC inspector and an Expert by Experience.

An Expert by Experience is a person who has had experience of using this type of service and helped us to capture the views and experiences of patients.

Background to Melbourne Road Health Centre - R Kapur

Melbourne Road Health Centre is a GP practice which provides a range of primary medical services to around 3,000 patients from a surgery in the centre of the city of Leicester. Their services are commissioned by Leicester City Clinical Commissioning Group (CCG). The service is provided by two GP partners, a long term locum GP, a practice nurse and a health care assistant who are supported by a practice manager, an assistant practice manager and reception and administration staff. Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has one location registered with the Care Quality Commission (CQC). This is at 47, Melbourne Road, Leicester. LE2 0GT. Melbourne Road Health is registered to provide the following regulated activities at that location: diagnostic and screening procedures, family planning,

maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury. This is the first inspection of the regulated activities carried out at this practice.

The surgery is in an older style, three storey converted building. Parking is available in surrounding streets and there is car parking space designated for use by people with a disability near the surgery entrance.

We reviewed Information from Leicester City clinical commissioning group (CCG) and Public Health England which showed that the practice population is affected by higher deprivation levels than the average for practices within the CCG and the average for practices in England.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by The Leicester, Leicestershire and Rutland Out of Hours Service.

Why we carried out this inspection

We inspected this practice as part of our new inspection programme to test our approach going forward and at the same time as a group of other practices in this CCG area. This practice had not been inspected before and that was why we included them in this group of inspections.

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?

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also reviewed information we had requested from the practice prior to our visit, as well as information from the public domain including the practice website and NHS choices.

We carried out an announced visit on 8 July 2014. During and subsequent to our visit we spoke with a range of staff including GPs, a practice manager, a nurse, a healthcare assistant and reception staff. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

During our visit we spoke with representatives of the patient participation group to gain their views on the service provided by the practice.

Are services safe?

Our findings

Safe Track Record.

We spoke with patients and reviewed comment cards completed by them during our visit to Melbourne Road Health Centre who told us they felt safe in their care and treatment at the practice. They said they had confidence in the abilities of the GPs and other staff at the practice. Patients told us they received prompt treatment and diagnosis. Patients also talked of the ongoing treatment, screening and health promotion that took place at the practice. Staff we spoke with were aware of their responsibilities to identify and report incidents and were able to correctly explain how they would report any incidents or concerns that they may have.

The practice had a detailed policy in place for handling patient safety alerts such as those from the Medicines and Healthcare Products Regulatory Agency (MHRA). We discussed patient safety alerts with the practice manager and were told the alerts were printed off and placed in the practice diary. We looked at the diary and there were a large amount of alerts loosely placed inside the diary, none were signed to say they had been read or actioned. The policy was far more robust stating they would be emailed internally to all relevant staff, added to the clinical meeting agenda and downloaded to an electronic file. We spoke with the practice nurse who confirmed that they received alerts via email. We saw no evidence that alerts had been discussed at meetings.

Learning and improvement from safety incidents

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

We looked at records of four significant events recorded at the practice over the previous 12 months. These included issues with blood samples and medication not being recorded correctly. Action required and learning outcomes were recorded and staff meetings were held relating to each significant event and minutes recorded. However two of the records stated they would be reviewed three months later to ensure actions had been implemented but there was no record that this had been completed and no system to ensure that it would occur. We were aware of two incidents, that were significant events but there was no record of them. We raised these with the practice manager

who told us they would record them retrospectively. This meant learning from these events may not have been identified or reviewed to ensure that necessary actions had been taken to improve patient safety.

Reliable safety systems and processes including safeguarding

The practice had a system in place to ensure patients were safeguarded against the risk of abuse. We saw there was a policy in operation relating to the safeguarding of both vulnerable adults and children. One of the partner GPs was the nominated safeguarding lead. All staff, clinical and non-clinical, had received training to the appropriate level for safeguarding vulnerable adults and children. Staff we spoke with were able to describe the signs to look for which may have alerted them to the possibility of a patient being at risk of abuse. They were also able to tell us the channels for reporting any concerns and we saw the information they would refer to. A receptionist we spoke with told us the practice had not made any referrals in the last year but had in the past.

The practice had a whistleblowing policy in place which gave staff guidance on how they could raise concerns with external agencies, if they felt that concerns were not being acted upon at the practice. The staff we spoke with were aware of the policy.

The practice had taken steps to ensure patient safety by minimising the risks of recruiting unsuitable staff. We looked at the system for recruitment and personnel records. The majority of staff were long standing but we saw there were suitable processes for the recruitment of new staff. The practice had checked that clinical staff had current registrations with their respective professional bodies.

The practice manager told us that if a locum was employed, relevant documents such as inclusion on the medical performers list and adequate indemnity cover were provided by the agency. In addition to this the practice manager told us they would check registration with the General Medical Council and verify photographic identification.

Are services safe?

Monitoring safety and responding to risk

One of the GP partners told us that they could quickly respond to an emergency situation such as a patient collapsing in the waiting room as the computer system had, by means of operating a panic button, the facility to alert all staff to the location of the incident.

We found there were inadequate systems in place to identify, assess and manage risks relating to the health, welfare and safety of patients and others. The practice manager told us that health and safety risk assessments were undertaken annually. We saw a document dated June 2013 which was titled 'health and safety checklist' but this did not incorporate any risk assessments. We saw a basic fire safety risk assessment table dated January 2014 which was due to be reviewed in March 2014. This lacked detail and was insufficient for its purpose.

During our inspection we saw that there were inflammable materials stored in the basement. We pointed this out to the practice manager and later that day they informed us the materials had been removed. There was no fire alarm in the practice and all smoke alarms were battery operated. There were recorded checks in place for the batteries in the smoke detectors. Fire drills had been documented as being completed every three months. Staff told us they had received fire safety training and were aware of the fire evacuation procedure. However, there was no safety information visible in the patients' waiting area such as the procedure for evacuation in the event of a fire.

There was no fire risk assessment in place. Following our inspection we were provided with a completed fire risk assessment checklist but not a full risk assessment. There were no risk assessments in place relating to the building.

Medicines management

We looked at the controlled drug register at the practice. This listed all patients who received repeat prescriptions for a controlled drug. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. The patient had to sign in the book to confirm when they had received their prescription for a controlled drug. This kept patients safe by ensuring the patient received the correct prescription and controlled drugs were only collected by the correct recipient.

We saw evidence that a daily stock take of medicines stored in the fridge took place and checks were made regularly of the expiry dates of medication to ensure it was still safe to use.

We looked at the fridge in which vaccines were stored and the system for monitoring temperatures. We saw that on the days when the practice nurse worked, minimum and maximum fridge temperatures were recorded in line with national guidance. However on the days of the week when there was no nurse clinic, the temperature was recorded by a receptionist and only the current temperature, not minimum and maximum temperatures were recorded. We saw in the temperature recording chart that there had been an incident in June 2014 where there was a problem with fluctuating temperatures. During this time vaccines were stored in a domestic fridge. We asked the nurse about the incident and they told us the practice had taken advice from Public Health England in order to check the vaccines were still safe to use. There was no formal incident report relating to this.

Cleanliness and infection control

Patients we spoke with during our visit told us they felt the practice was clean and one patient told us they had not been happy with the cleanliness at the practice but it had improved recently. We saw that clinical and communal areas and toilets appeared visibly clean.

The health care assistant at the practice was the nominated infection control lead, supported by the practice nurse. The practice manager told us that daily cleaning of the premises was carried out by an independent contractor six days per week. There was a cleaning schedule included in the service level agreement with the cleaner which indicated routine tasks. There were no schedules to indicate that cleaning tasks other than in the toilets had been completed. We saw records of privacy curtains being cleaned every three months to reduce the risk of cross contamination.

Risks associated with injury and infection from the handling needles and blades were minimised. Staff that we spoke with were familiar with the practice's policy on sharps and all clinical areas had a suitable sharps bin. Staff records showed that clinical staff had up to date immunisations for Hepatitis B, to protect them from risks of

Are services safe?

contagious diseases. There were sufficient supplies of disposable gloves, aprons and bed rolls. The use of that equipment supported the practice to minimise risks of infection.

The practice had appropriate clinical waste storage and a contract in place with a clinical waste disposal company.

We found that there was no legionella risk assessment in place and we did not see any evidence that legionella checks had been carried out at the practice. Therefore the necessary steps had not been taken to identify, assess and manage risks relating to the health of patients or others who may have been at risk.

Staffing and recruitment

One of the partner GPs told us that when they used locums they tried to use the same ones to ensure continuity patient safety was maintained by monitoring prescriptions and referrals.

We were told by the practice manager that they were currently short of reception staff but were in the process of recruiting. They told us that in the meantime other staff were happy to work extra hours to cover the shortfall. This was confirmed by reception staff.

The skill mix of the GPs was comprehensive and covered diabetes, psychiatry, orthopaedic, musculoskeletal, gynaecological and family planning. This ensured that patients were kept safe and their needs were met.

Dealing with Emergencies

The practice had a business continuity plan in place to ensure continuity of the service in the event of serious or ongoing problems at the premises. The plan gave details of what actions to take dependent on the type of problem.

We saw that emergency medicines and equipment were kept at the practice. We saw records which showed that these were checked on a regular basis to make sure they were safe and still in date. Staff told us and we saw records that they had received training in basic life support to enable them to deal with emergency medical situations.

One of the partner GPs told us that the practice received Better Care Fund (BCF) from Leicester City CCG to manage extra demands on services such as winter pressures and use it to employ extra staff when needed.

Equipment

The practice had arrangements in place to ensure equipment was maintained and safe to use. We saw records which showed that portable appliance testing had been carried out annually. Staff told us calibration was undertaken on equipment which required it, on an annual basis.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment given in accordance with national guidelines. We found that the practice was working to national best practice. We were told they referred to guidance from The National Institute for Health and Care Excellence (NICE). We saw the computer system the practice used enabled the GPs to work to national best practice as they were able to access all tests and questions relevant to common conditions when the condition was entered on the system.

The practice participated in recognised benchmarking and assessment programmes such as Quality Outcomes Framework (QOF) and local and direct enhanced services. Information from QOF audits which we looked at reflected that the practice had scored highly which demonstrated that patients received care and treatment according to national guidelines.

The consent policy which the practice had in place gave guidance on Gillick competencies. Gillick competence is recognised guidance used to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were familiar with its use and described how children were involved in their care and treatment in line with this guidance.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included antibiotic prescribing, international normalisation ratios (INR - a test to measure how fast a patient's blood clots), and non-steroidal anti-inflammatory drugs (NSAID). At the time of our inspection one of the GPs was undertaking a clinical audit on the use of inhaled steroids in chronic obstructive pulmonary disease (COPD).

One of the GPs in the practice undertook minor surgical procedures which we found was in line with their registration and NICE guidance. The staff were appropriately trained and their training was kept up to date.

We found that the practice had a register of patients with long term conditions which was monitored and updated regularly. There was advanced care planning in place for patient groups with three or more long term conditions. Advanced care planning is to plan ahead as much as possible to ensure timely access to safe, effective care and continuity in its delivery to meet the patient's needs.

Staff said that the practice meetings they attended were useful and informative. They said that ideas on how to carry out procedures more effectively and the continual improvement of issues relating to patient care were addressed.

Effective staffing, equipment and facilities

The patients we spoke with and comment cards we reviewed were positive about the levels of knowledge and professionalism of staff at the practice.

The practice manager told us that any newly appointed staff would receive an induction which included an explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

There was an effective system in place for monitoring staff performance. The GPs had internal and external networks of clinical support. We discussed the appraisal system with staff and were told that appraisals for non clinical staff were undertaken by the practice manager and clinical appraisals by the practice manager and a GP. We looked at an appraisal of one of the GPs and saw it was up to date. Reception staff we spoke with told us they had recently received an appraisal with the practice manager and we saw records of appraisals from previous years. Staff members told us their training needs and development were discussed as part of the process and they had been supported to take further qualifications appropriate to their role. This included areas such as chaperone training, advanced training in diabetes, national vocational qualifications (NVQ's) as well as mandatory training in areas such as fire safety, basic life support and safeguarding vulnerable adults and children.

Staff were able to access the Leicester training directory and chose training they felt would be useful to them. The practice manager would then discuss the requests with a partner GP and training was agreed. All staff we spoke with felt they were able to access sufficient training. This was reflected in the records we looked at.

Are services effective?

(for example, treatment is effective)

We saw records which confirmed that professional registrations of relevant staff were up to date.

Working with other services

A patient we spoke with described their positive experience of being referred to other services and said the process had been seamless.

We found there was an effective and clear system in place for managing blood test results and recording information from other health care providers. We spoke with administration staff who told us that incoming notifications or discharge letters were reviewed daily by a GP who made any necessary changes to records such as medication changes and then notated any actions for administration staff who carried them out and updated records accordingly. Similarly with blood tests the results would be reviewed by a GP who would then inform the receptionist to contact patients to book an appointment if required. We saw evidence of these processes.

We were given examples of how the practice worked with other services which included regular meetings with the Macmillan nurse to discuss the care of patients with cancer. We also saw minutes of one of these meetings. One of the GP's we spoke with told us that the practice had links with

drug and alcohol services who they referred to and there was also a recently formed GP led dementia service available. This demonstrated an integrated approach to the care and treatment of patients.

Health, promotion and prevention

All new patients were offered a consultation with a GP to assess their health status and identify their ongoing needs. One of the GP's told us that during these consultations they would address areas such as diet and smoking and make referrals or signpost to other providers or agencies for further specific support. Depending on the outcome of their initial assessment patients were then monitored for long term conditions with regular checks as necessary such as blood pressure monitoring.

We found a great deal of health promotion and prevention information on display and available at the practice. This was in the form of leaflets and posters. However, the information on display was only available in English. We were told that the CCG also produced a quarterly newsletter which was delivered to all homes in Leicester city and included health promotion information and advice. The most recent issue had focused on mental health and older people and covered topics from depression and dementia to anxiety.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with six patients during our inspection. We met with two members of the patient participation group (PPG) who represented views of patients through surveys and meetings with the practice. The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. We reviewed 32 comment cards from patients or their relatives who shared their views and experiences of using the practice.

The national GP NHS patient survey regarding the practice which was carried out in 2012 – 2013, showed that 87% of patients surveyed said the last GP they saw or spoke to was good at listening to them.

During our visit we observed staff interactions with patients and saw they were caring and supportive of patients and had a compassionate attitude. We observed staff during telephone conversations with patients and heard them talking in languages other than English. Staff were patient and polite during telephone calls with patients. One receptionist told us she was able to speak four of the most common languages spoken by patients.

Patients we spoke with told us they found the staff kind and caring and that GPs were easy to talk to. The comment cards completed by patients reflected on the whole that the majority of patients found the staff and GPs helpful, accommodating and attentive, and felt well looked after. Patients said the GPs and nurses took their time and explained things. They felt they were able to ask questions. Conversely, one patient reported that sometimes the GPs seemed rude in the way they had been spoken to but still felt their care and treatment was good.

We spoke with one of the GPs who told us doctors and other staff were able to speak the language of the majority of patients and understood and respected their personal and religious beliefs. We observed this on the day of our inspection as it took place during the month of Ramadan. A large proportion of patients were respecting and taking part in it in line with their beliefs. We heard receptionists accommodating patients' varying needs according to the restrictions they were observing by participating in Ramadan.

The practice had procedures in place to respect patients' dignity. We saw the practice had a chaperone policy and posters were displayed in reception areas and treatment rooms informing patients of the availability of chaperones. Staff we spoke with confirmed their roles and responsibilities when chaperoning and told us they had received relevant training.

We received and reviewed comments from patients about a lack of privacy in the reception area of the practice. We spoke with receptionists at the practice who told us that if a patient wanted to speak privately they had the facility to take them to the side of the reception area which was slightly more private or alternatively to an empty consulting room.

The practice had access to counsellors who were able to support patients and also signpost them to other agencies for support in circumstances such as bereavement.

Involvement in decisions and consent

Patients we spoke with or who completed comment cards, said they felt involved in decisions about their care and treatment. They felt they were listened to and were comfortable to ask questions.

The practice had a consent policy in place. The policy also covered children's consent. The consent form had a section for children to sign (in addition to parents) if they wished. One of the GP's we spoke with told us that in accordance with their policy, patients over 12 years of age were given the chance to speak to them on their own if they wanted to, without their guardian being present.

We spoke with the practice nurse who demonstrated knowledge and understanding of the Mental Capacity Act 2005 and consent issues. They explained how important it was to use an interpreter when there were language difficulties in order to ensure that informed consent was given by patients.

We were told that an interpreter was available at each nurse clinic because of the high proportion of patients whose first language was not English. Some of the standard letters were available in other languages to enable patients to be involved in their care and treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We asked the practice manager how the practice understood the differing needs of the population it served and acted to accommodate their needs. They told us that the majority of their patients did not speak English as a first language and they called on a local interpreter service as required. The GPs and receptionists all spoke the most common languages of their patient population and as the practice nurse was English speaking an interpreter was available at every practice nurse clinic.

There was an online service available for communication with patients who had hearing difficulties.

The practice had made reasonable adjustments to the premises in order to make the practice accessible to wheelchair users as they had installed ramps into the reception area and GP consulting rooms. Handrails had also been installed and there was a toilet for the disabled near the surgery entrance.

The practice nurse's room was on the first floor and was accessed by a steep narrow staircase. We asked the practice manager how anyone who had difficulty using the staircase would be able to access an appointment with the nurse. They told us that in these instances the nurse would use one of the consulting rooms on the ground floor. This was confirmed by the practice nurse we spoke with who said she would also do home visits for patients who had difficulty accessing the practice. An example of this was to go to a patient's home to administer a flu vaccine.

During our inspection we spoke with two members of the patient participation group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. They told us that they had reviewed the number of appointments that were made but not attended (DNAs). They said they had worked with the practice and when a patient had not attended an appointment three times; the PPG sent a letter to the patient. They told us that as a result of this the number of DNAs had been reduced.

Access to the service

We found that the practice was accessible. Patients were able to make appointments online, on the telephone or in person. There were pre-bookable and on the day appointments available every day. The practice manager

told us the opening hours of the practice had been extended in response to patient comments in order to make the service more accessible. The practice was open until 6.30pm on weekdays and GP appointments were available on Saturdays until 3pm. Patients we spoke with on the day of our visit told us it was easy to get an appointment with their chosen doctor and confirmed that same day appointments were always available. The practice manager said that the GPs worked longer to meet demand.

The opening hours were displayed in the practice and on the website as well as information about how to access GP services when the surgery was closed.

Home visits were available for patients who were not able to attend the practice and telephone consultations were also offered where appropriate. Repeat prescriptions could be ordered online, over the telephone or in person. Patients we spoke with told us the system for repeat prescriptions worked well and they received their prescriptions in a timely manner.

Information about online services regarding appointments and prescriptions was clearly displayed in the patient waiting area but like the rest of the leaflets and posters available the information was only available in English. We spoke with a GP regarding the lack of information in other languages. He told us that as the majority of patients at the practice did not read English, the practice had installed a television screen which would be used to display information in multiple languages.

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 was a designated responsible person to handle all complaints in the practice.

The complaints policy which the practice had in place stated it was due to be reviewed in April 2014 but there was no reviewed policy available. We found there was insufficient information available to patients to enable them to raise a complaint. The only information available about making a complaint was in the practice leaflet which advised patients to contact the practice manager. This was only available in English. There was no information available about the complaints procedure or details of support available to make a complaint in the patient

Are services responsive to people's needs?

(for example, to feedback?)

waiting areas or on the practice website. The receptionist told us there were complaint forms available if a patient requested one. The practice manager told us there had been one verbal complaint in the last 12 months but was unable to provide details of this.

Comments on NHS Choices from October 2013 and May 2014 had not been responded to on the website. The practice manager told us they had not been aware of the comments and therefore had not responded.

There was a suggestion box in the waiting room with a poster above it inviting comments, suggestions and complaints. The information was only in English. The reception staff told us the box was checked daily and there had never been any suggestions posted.

Are services well-led?

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

Our findings

Governance Arrangements

The practice had a range of policies and procedures in place to inform clinical practice. Staff leads had been identified for infection control and safeguarding. There were clear lines of responsibility with designated lead roles. Staff were able to seek guidance from other colleagues to support them.

Practice issues were discussed formally and informally. We saw minutes of meetings which reflected issues had been discussed and actions identified. The practice nurse was also able to participate in a regular nurses forum to gain support and share information with other practice nurses in the area.

Systems to monitor and improve quality & improvement (leadership)

Leicester City CCG undertook an annual quality review (AQR) of all practices from whom it commissioned services. The practice had undergone an AQR visit in December 2013 and were rated green by the CCG which is the highest of three grades. An improvement plan had been put in place in order to achieve further improvement and we saw evidence that the practice were on target to complete the requested actions.

Patient experience and involvement

The practice had an established patient participation group (PPG) and there was information for patients about what the PPG did and how to join displayed in the surgery and also on the practice website. The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. Views on patient experience had been gathered by means of a survey conducted by the PPG and the results which were largely positive were available on the practice website.

Practice seeks and acts on feedback from users, public and staff

Staff we spoke with told us they felt the practice worked well together as a team and felt supported by management and could approach them with any issues. They felt they were listened to and were able to give clear examples of when their ideas or suggestions had been implemented.

Clinical staff we spoke with felt well supported and respected in their role. One of the partner GPs told us that good communication between all staff was a priority in the practice.

The PPG had been running for three years and was made up of approximately eight members who met quarterly. The chairperson told us that they had found it difficult to recruit membership from the younger population. We spoke with two members of the PPG. They told us the group had been trying to raise money to install a blood pressure machine in the waiting area. One member told us concerns had been raised with the practice management regarding appointments and not being able to get through on the telephone. The outcome had been to educate patients regarding appointments for minor ailments and inappropriate attendance at the accident and emergency department. However they told us there was no formal process agreed to achieve this.

One member said they had been involved with the development of the patient satisfaction survey. This had been conducted by means of a questionnaire and there were no individual comments or issues reported in the results. Patients were asked how they would rate their experience of their GP surgery and 95.9% of patients said it was either 'good' or 'fairly good'. We saw minutes of PPG meetings from the last 12 months which, following the survey incorporated an action plan agreed with the practice management to address issues of concern raised. These included increasing confidentiality in the waiting room, providing surveys in the future in different languages and advertising to encourage more people to register as carers with the practice.

Management lead through learning & improvement

The practice participated in protected learning time (PLT) on a monthly basis. Protected Learning Time (PLT) is an opportunity for practice staff to address their own learning and professional development needs. Practices in a locality meet to allow for Continuing Professional Development learning activities. The practice was closed to enable all staff to attend and the out-of-hours service covered patient needs. We saw that this closure was advertised to patients in advance.

Are services well-led?

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

The practice manager was clear about how poor performance of staff would be managed although they told us this had never been an issue as the staff were loyal and dedicated.

Identification and management of risk

We found that certain areas of risk such as some significant events were discussed at staff meetings.

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

The practice was safe, effective, caring, and responsive for patients who were aged 75 and over. Older patients that we spoke with told us they felt well cared for and that their long term conditions were well managed.

Each patient over the age of 75 was assigned a named, accountable GP who would have overall responsibility for the care and support of the individual patient. Letters had been sent to inform those patients who their nominated GP was.

GP appointments were offered on the same day and GPs would carry out home visits for those older people who were housebound, frail or too ill to attend an appointment at the surgery.

Flu vaccinations were available to older people in the autumn and the practice nurse told us that if patients were unable to attend the surgery for their vaccination they would organise a home visit.

The practice had advanced care planning in place for older patients with three or more long term conditions.

There was a health and social care co-ordinator (HSCC) for each locality in the city. This was a named person for each area who could be contacted to co-ordinate health and social care issues for over 70s and end of life care when needed. This indicated that the practice worked holistically with older patients as well as meeting their primary health needs.

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

The practice was safe, effective, caring, and responsive for patients with long term health conditions.

Patients that we spoke with told us that they felt their long term conditions were dealt with well. They said that GPs were effective at monitoring and identifying problems with their existing condition. Patients said they felt involved in the care they received. Records showed that staff worked effectively with other agencies to ensure people had the care and treatment which was planned in line with their needs. We saw evidence of regular multi disciplinary meetings with a Macmillan nurse regarding patients who had cancer.

The practice had a high prevalence of patients with diabetes. There was a lead GP for diabetes and the practice nurse was undertaking further specialised training in this area.

Staff we spoke with told us that patients with long term conditions were monitored by means of a yearly review with the practice nurse and blood tests every six or 12 months dependent upon their condition. A medication review was also carried out by a GP every six months or sooner if required.

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 was safe, effective, caring, and responsive for mothers, babies, children and young people.

Parents we spoke with were very happy with the care their families received. They told us they had no difficulty in obtaining appointments for their children.

Antenatal care for support through pregnancy was accessed through midwives who worked with the practice. Midwives held sessions at the practice once a week. There was also postnatal services for new mothers.

Appropriate systems were in place to support prompt referral of safeguarding issues relating to children.

There were baby and childhood immunisation programmes available.

A consent policy was in place which related to children.

Family planning information and services was available.

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 was safe, effective, caring and responsive for working age people and those recently retired.

The practice had an appointment system which enabled people of working age to get an appointment when they needed one. On the day appointments, telephone consultations and on line appointment booking was

available. Extended opening hours were provided until 6.30pm on some weekdays, and 3pm on Saturdays and bank holidays for people whose work commitments made it difficult to attend a weekday appointment.

Information was widely available at the practice about healthy lifestyles and prevention of illness. NHS health checks were available to working age people.

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

The practice was safe, effective, caring, and responsive for patients in vulnerable circumstances or who may have had poor access to primary care.

The practice had a safeguarding vulnerable adults policy in place and a nominated safeguarding lead. Staff we spoke with were aware of how to identify and raise any concerns.

We were aware that there was a GP practice in Leicester city which had been commissioned to provide GP services specifically for homeless and vulnerably housed patients and the practice manager told us that they would automatically refer patients to this service if they were in that situation.

People who were staying locally for a short time were able to register with the practice as a temporary patient.

We were told that sex workers were provided immediately with emergency contraception such as the morning after pill or referred to the nearby St Peters Health Centre.

Staff we spoke with told us that patients with learning disabilities were monitored by means of an annual review. A GP would also carry out a medication review every six months or sooner if required. Same day appointments were available for patients with a learning disability.

The practice provided signposting to other services which could support patients in vulnerable circumstances. The practice had a high number of patients who did not speak English and staff were aware of how to access language interpretation services, a number of staff spoke other languages and an interpreter was available at every practice nurse clinic as they only spoke English. GPs described how they had links with drug and alcohol services locally and would signpost or refer patients as required.

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

The practice was safe, effective, caring, and responsive for patients experiencing poor mental health.

The practice worked with local mental health services. Staff had received training in and were aware of the requirements of the Mental Capacity Act (2005).

There was a mental health clinic held at the practice on a fortnightly basis which GPs could refer patients to. This was run by another provider.

Same day appointments were available for patients experiencing poor mental health.

Blood tests were carried out on an annual basis and medication reviews were carried out frequently by a GP unless the patient was under secondary care in which case incoming letters would be reviewed and medication updated accordingly.

Melbourne Road Health Centre - R Kapur

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

The practice provides GP services to approximately 3000 patients in the centre of Leicester city from Melbourne Road Health Centre, Melbourne Road, Leicester. The premises is an older three storey building. The practice provides a range of primary medical services which includes family planning and minor surgery.

This was an announced inspection, which focused on whether the care and treatment of patients was: safe, effective, caring, responsive and well led. We spoke with six patients and two representatives of the patient reference group (PPG). The PPG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. We reviewed written and verbal feedback from patients and observed how staff interacted with patients. The majority of the feedback about patients' care and treatment was positive.

We reviewed Information from Leicester City clinical commission group (CCG) and Public Health England.

We found the practice understood the local patient population and provided flexible and responsive services to meet their needs. Patients told us they found the service accessible and were involved in making decisions about their care and treatment.

Staff we spoke with told us they were well supported by the GPs and practice manager and that they found them open and approachable. We saw that there were systems in place to safeguard vulnerable adults and children from abuse.

We found 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.

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.