# Spinney Hill Medical Centre

## Quality Report

143 St Saviours Road, Leicester, LE53HX
Tel: 0116 319 2568
Website: www.spinneyhillmc.co.uk

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Spinney Hill Medical Practice on 27 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should;

- Provide complaints information in languages other than English.

# Summary of findings

- Consider training for non-clinical and administration staff to encourage and enable them to report significant events.
- Ensure that written records are maintained of mutli-disciplinary meetings.
- Develop a system for the chronic disease management of the housebound and those living in care/nursing homes.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

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

**Are services effective?**

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand, although we found that written information wasn't always available in alternatives to English. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain

# Summary of findings

was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. We noted that the information about how to complain was only available in English.

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

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

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. We did note however that there was no formal structure in place for managing patients with long term conditions who were living in residential or nursing homes.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

**Working age people (including those recently retired and students)**

Good

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

# Summary of findings

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 80% of these patients had received a health check in the financial year to date. It offered longer appointments for people with a learning disability.

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

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 93% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

# Summary of findings

## What people who use the service say

During the course of the inspection we spoke with nine patients.

We also provided comments cards to enable patients to share their experiences with us. 28 patients completed the cards.

They told us that the care and treatment they received was good and that they felt fully informed of their treatment options. The patients we talked with, and the patients who had completed comments cards, emphasised the caring attitude of the staff and the quality of the treatment they received.

Two patients said it was sometimes difficult to get an appointment to see a GP on the same day.

Patients told us they always found the premises clean and hygienic.

## Areas for improvement

**Action the service SHOULD take to improve**

Provide complaints information in languages other than English.

Consider training for non-clinical and administration staff to encourage and enable them to report significant events.

Ensure that written records are maintained of mutli-disciplinary meetings

Develop a system for the chronic disease management of the housebound and those living in care/ nursing homes

# Spinney Hill Medical Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and a GP and the team included an additional CQC inspector and a practice nurse.

## Background to Spinney Hill Medical Centre

Spinney Hill Medical Practice provides primary medical services to approximately 12,000 patients from the surgery at 143 St Saviours Road, Leicester. The provider has another practice at 132 Doncaster Road, Leicester with 7,000 patients. The Doncaster Road surgery has a distinct and separate CQC registration and was not inspected.

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

The practice has opted out of the requirement to provide GP services outside of normal hours. The out-of-hours service is provided by The Leicester, Leicestershire and Rutland Out of Hours Service.

The practice serves an almost exclusively (99%) Asian and Asian British population with a significant proportion of those newly arrived in the United Kingdom. The most commonly spoken languages are English, Gujarati, Hindi and Punjabi. The patient list has risen by 750 in the six months prior to our inspection.

The practice is staffed by eight GP partners and one part time salaried GP, giving a whole time equivalent (WTE) of 8.4. One of the GPs is female. They are assisted by 3.25 WTE practice nurses, three health care assistants and one phlebotomist. The clinical staff are supported by a team of receptionists, administration and information technology staff. The practice is a teaching practice for GP trainees. Three of the GP partners are GP trainers.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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

## How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

# Detailed findings

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People whose circumstances may make them vulnerable

• People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice.

We carried out an announced visit on 27 November 2014. During our visit we spoke with a range of staff including GPs, nurses, healthcare assistants, reception and administration staff. We spoke with patients who used the service. We observed the interactions between patients and staff, and talked with carers and family members. We met with the chair of the patient participation group (PPG). 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 improve quality of care.

We reviewed 28 CQC comment cards on which patients had shared their views and experiences of the service.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

Good

# Are services safe?

## Our findings

### Safe track record

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

National patient safety alerts were disseminated by the practice computer system to all practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, an example being the outbreak of the Ebola virus in West Africa. They also told us alerts were discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

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

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last year and found that all reports related to clinical incidents. One of the GPs told us that significant events were a standing item on the practice meeting agenda at least every three months or sooner if required. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We were told that incident forms were available on the practice intranet, however some non-clinical staff we spoke with were not aware where to locate an incident form but said they would report anything untoward to their line manager. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, following incidents relating to a piece of equipment, the practice reviewed their process and a nurse was now responsible for calibrating the machine before every session.

### Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern. The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw evidence that unwell children were always seen on the same day by a GP.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the consultation.

### Medicines management

Nursing staff undertook a weekly stocktake of all medicines and we saw evidence of this, with travel vaccines ordered monthly and other vaccines as required.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring that medicines were kept at the required temperatures, and which described the action to take in the event of a potential failure. The practice staff followed the policy. Fridge temperatures for all three fridges were monitored in line with best practice. We looked at the data for the last twelve months and found it to be complete and the fridges to be operating correctly. We saw that the practice had recently purchased data loggers to cross check the accuracy of the monitoring.

Staff were aware of the importance of maintaining the cold chain for certain vaccines to ensure their efficacy and were able to describe the process for maintaining the cold chain.

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

We saw records of practice partner meetings that noted the actions taken in response to a review of prescribing.

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

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

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. All rooms were tidy and free of clutter.

All clinical rooms had impermeable, easy clean flooring. Some none clinical rooms were carpeted but we saw these were visibly clean and stain free.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received updates. We looked at the last infection and prevention control audit and the saw and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We observed one member of staff washing their hands and saw they displayed very good technique. Clinical rooms were fitted with disposable privacy curtains which were within date.

The practice had a policy for the management, testing and investigation of legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

**Equipment**

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

**Staffing and recruitment**

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body such as the General Medical Council in the case of GPs and the Nursing and Midwifery Council in the case of nurses. Criminal records checks through the

Good

# Are services safe?

Disclosure and Barring Service (DBS) had been undertaken. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

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

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. All employees were given a health and safety handbook which was also available on the practice computer system.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

**Arrangements to deal with emergencies and major incidents**

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

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

The practice had carried out a fire risk assessment and no actions had been identified as being required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. We were present when a clinical meeting took place, involving all clinical staff, at which reviews of elective and urgent referrals were made and discussions took place as to how any improvements could be made to improve patient outcomes. We saw that these weekly meetings were documented and made available to staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. We found that GPs and staff were mindful of patients' religious persuasion and new patients were asked to state their preference of the gender of their clinician and times that they would like to avoid when making non urgent appointments, such as Ramadan or other holy days.

**Management, monitoring and improving outcomes for people**

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

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. The practice had a GP who was the lead for conducting clinical audits and they showed us clinical audits that had been undertaken for example prescribing ,the use of nutritional supplements and clostridium difficile infection (a type of bacterial infection that can affect the digestive system). These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example we saw the audit that had been commenced concerning the prescribing of non-steroidal anti-inflamatory drugs. A re-audit had been completed a year later. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, a GP told us that the practice had a relatively low prevalence in the diagnosis of chronic pulmonary obstructive disease. The practice had responded by providing additional training for GPs and nurses to raise their awareness of the condition and more effective interpretation of spirometry results. We also saw that the percentage of diabetic patients with well controlled blood glucose levels was lower than the national average. We discussed this with the medical staff who told us that poor control of blood glucose levels had always been a problem in the Asian community, but they were addressing the issues by providing advice on medication during religious festivals such as Ramadan, which involved an element of fasting.

Good

# Are services effective?

## (for example, treatment is effective)

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

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

The practice was an enhanced diabetic practice and undertook insulin initiation and adjustment. Insulin was initiated by GPs only. This enhanced service negated the need for patients to attend hospital out-patients appointments. All newly diagnosed diabetics were referred to the local hospital for support and also for retinal screening. The lead nurse for diabetes telephoned patients when their reviews were due and an alert on System One notified clinicians that recalls were due.

One of the health care assistants was trained on the DESMOND (Diabetes Education and Self-Management for Ongoing and Diagnosed) course and offered diet and lifestyle advice for patients.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Multidisciplinary meetings were held every two months or more frequently if required, although we were informed that no formal minutes of the meetings were recorded.

The practice provided all residential settings where patients were living with a direct dial telephone number to allow prompt access to the receptionists and bypass any potential delay in seeking medical advice.

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

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with them having additional diplomas in, for example, children's health, obstetrics and gynaecology and sexual and reproductive healthcare. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice nurses and health care assistants were suitable qualified with all healthcare assistants having achieved or working towards National Vocational Qualification Level 3 in Health and Social Care.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology .Those with extended roles

Good

# Are services effective?

## (for example, treatment is effective)

for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

**Working with colleagues and other services**

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly or more frequently if necessary to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. However we were told that these meetings were not formally minuted so there was little written record of what was discussed other than in patients' individual records.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, SystmOne, to coordinate, document and manage patients' care. All staff were trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified for example with errors or miscoding which may have resulted in the low prevalence of conditions such as atrial fibrillation.

The practice nurses told us they had excellent support from the community midwifery team, who referred pregnant patients for boostrix (a booster immunization against tetanus, diphtheria, and pertussis) and flu vaccines.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. This practice policy relating to Mental Capacity highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear

Good

# Are services effective?

## (for example, treatment is effective)

understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

**Health promotion and prevention**

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic childhood immunisations in addition to the routine immunisation clinics.

The practice offered NHS Health Checks to all its patients aged 40-74. We saw evidence that the practice was working with the CCG to increase the numbers of patients in this age group took up the offer of the health check.

We saw that 80% of the 102 patients on the learning disabilities register had received an annual physical health check from April to November 2014. During the same period 93% of the 145 patients on the mental health register had received an annual physical health check.

We saw that the Muslim Council of the UK had supported the fluenz nasal vaccine this year for two to four year olds, (as there had been concerns from the Muslim community due to the gelatine content in the vaccine). There was a program in place to make parents aware of this and the guidance from the council was attached to appointment letters. Uptake of the vaccine had increased as a result.

We were aware that uptake of cervical screening was lower than the CCG and national average and we were told that historically the uptake had been low. The practice acknowledged the issue and was taking steps to improve uptake by trying to overcome the cultural apprehensions and challenges. The practice was providing additional training for a practice nurse to support the lead nurse in this field. Opportunistic smears were being promoted. The practice had a system in place for recalling women who had failed to attend their appointments for cervical screening.

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

Contraception and sexual health was available to all young people, including incorporating a full range of contraception options.

Chlamydia screening was offered at the practice and there was a local clinic which also offered screening and emergency contraception, where young people were more likely to attend.

A GP was the lead for anti-coagulant therapy, but healthcare assistants and practice nurses completed the finger-prick blood testing and dosing respectively under the guidance of the lead GP.

Training and yearly updates were in place for GPs, practice nurses and health care assistants.

We noted that there was no structure in place for regular monitoring of chronic disease patients who were living in residential and nursing homes or who were confined to their homes. Monitoring was conducted on an ad hoc basis; if the GP was visiting then the chronic disease management occurred at that visit.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the practice patient experience survey in March 2014, which generated 305 responses. The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice also performed well for its satisfaction scores on consultations with doctors and nurses with 95.7% of practice respondents saying the GP was good at listening to them and 92.1% saying the GP gave them enough time. However data from the national patient survey showed the practice was rated 'among the worst' for patients who said they would recommend the practice at 66.1%. The practice was aware of this poor result and had carried out its own survey in September and October 2014. In this survey 87% of respondents had said they would recommend the practice to friends or family.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However we saw that during the morning the health care assistants used three cubicles for the purpose of taking blood tests, blood pressure readings and weight monitoring and all conversations could be overheard. In the afternoon clinics it was used by one practitioner only, therefore confidentiality was maintained.

The practice switchboard was located in a different room to the reception desk which helped keep patient information private. We noted during our inspection that confidentiality was maintained at the reception desk by means of a barrier set back well back from the reception which encouraged only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. There was also a separate room which could be used at patients request to secure confidentiality.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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

The practice operated a policy of actively offering patients a second medical opinion where any uncertainty existed.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the practice patient survey showed 95.8% of practice respondents said the GP was good or fair at explaining their problems and treatment option. The results and 94.1% of patients said they were sufficiently involved in making decisions about their care. The results were comparable with the CCG average.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

Good

# Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

For those patients on the 'avoidable unplanned admissions' register, care plans were in place that were reviewed every three months or straight away if an unplanned admission did occur.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. However this notice was in English only. We spoke with the practice manager who told us they would source material in alternative languages. This enabled patients to be fully involved in their healthcare decisions and options.

**Patient/carer support to cope emotionally with care and treatment**

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93.7% of respondents to the practice patient survey rated the GPs as good or fair. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

GPs displayed a deep and meaningful understanding of their patient's cultural backgrounds, for example they always tried hard to complete death certification within 24 hours for Muslim families to help them with religious observance.

Information in reception and clinical rooms was available in languages appropriate for the practice population. GPs and nurses sign posted patients to third party support organisations such as LOROS, (a local hospice), and to Macmillan nurses. A child bereavement counsellor was also available.

During our inspection we witnessed an elderly Gujarati speaking patient, accompanied by their son, who attended for anticoagulant testing. During the course of his consultation they mentioned other issues and stated that they were tired of living. The nurse responded compassionately to his concerns and due to their state of his of mind referred them to the GP. At the same time the nurse also offered support to the son. The nurse was able to speak a few words of Gujarati.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

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

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example we saw that the CCG and the practice had arranged for Age UK to visit the practice to help them raise patient awareness of what support was available for carers and cared for patients. There was also work in progress to accurately record the ethnicity of every patient at the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We spoke to the Chair of the PG who told us how the group had worked with the practice to revert to a local rate telephone number, rather than an 0844 number (which incurs higher charges) to alleviate the burden on patients living in deprived circumstances.

**Tackling inequity and promoting equality**

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

One of the GPs we spoke with told us that they if a homeless patient walked in to the practice they would be seen but they could also refer them to a practice in Leicester city which was specifically for homeless or vulnerably housed people.

The practice had access to online and telephone translation services and some GPs and reception staff spoke the main languages of the practice population.

The practice was situated on the ground and first floors of the building. There was lift access to the first floor. The waiting area and corridors were wide enough to make movement around the practice easy with wheelchairs and prams and helped to maintain patients' independence. Treatment and consultation rooms were easily accessible. Toilet facilities were available for all patients attending the practice including for the disabled. There were automatic doors at the entrance to the practice.

The practice had access to online and telephone translation services. The GP's spoke a number of different languages, in addition to English, and dialects as did some members of the nursing and non-clinical support staff.

The practice provided equality and diversity training through e-learning. Staff we spoke with and evidence we saw confirmed that they had completed the equality and diversity training.

**Access to the service**

Appointments were available from 08.30 am to 6.30pm three days of the week and until 7 pm on two days of the week. Pre bookable appointments were also available on a Saturday morning from 8.30 am to 11.30am. The practice was closed on Wednesday afternoons.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The patient survey showed that 51% of respondents said they got an appointment the same day.

Appointments were available outside of school hours for children and young people and the premises were suitable for children. Longer appointments were available for patients who needed them such as those with long-term conditions, older patients, those suffering poor mental health and patients with learning disabilities. Home visits were also available when necessary. The practice's extended opening hours three evenings a week and on a Saturday was particularly useful to patients with work commitments.

One of the GP partners led on access to appointments and he told us that the practice had previously carried out

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

demand and capacity analysis of the appointment system and had changed their system to provide appointments throughout the day in line with demand. They had also carried out an audit of response times to telephone calls. He told us that the practice had a strategy meeting planned in January 2015 to reassess access to the practice.

Patients were generally satisfied with the appointments system, although some had stated that it was sometimes very difficult to get through on the telephone. Comments received from patients showed that patients in urgent need of treatment were able to make appointments on the same day of contacting the practice.

The practice's extended opening hours until 7pm on two days a week and Saturday mornings were particularly useful to patients with work commitments.

**Listening and learning from concerns and complaints**

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

We saw that information was available to help patients understand the complaints system. However the information was only available in English despite the large number of patients whose first language was not English.

The practice complaints procedure was available in the patient waiting area and on the practice website. The complaints procedure gave guidelines to patients as to how to raise a complaint and what they could expect from the practice in response to a complaint. There were no details of advocacy support available for help with raising a complaint or contact details for NHS England. Details of the Health Service Ombudsman were included for patients to contact if they were not satisfied with the outcome of their complaint to the practice.

There had been seven recorded complaints received by the practice in the last 12 months. We looked at three of these and saw they had been dealt with appropriately and were responded to in a timely manner. We also saw detailed reflective reviews written by GPs relating to two of these complaints which described the learning from the complaint, how practice had changed as a result and when the learning had been shared with other relevant staff members. For example, as a result of one complaint the practice would now consider gaining a paediatrician's opinion when a baby presented with certain symptoms.

We were told by the practice manager that complaints were discussed at regular practice meetings. This was confirmed by staff members we spoke with but there were no minutes to reflect it. The practice had not formally reviewed complaints on an annual basis to detect themes or trends.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. The practice had acknowledged the challenges posed by the increasing demands for quality healthcare and outcomes for patients whilst managing diminishing budgets. In addition four of the GP partners had retired in the last six years and new partners had been recruited. This had placed some demands on the service as they familiarised themselves with the practice but all were now settled into their new roles. The result was that the average age of the GP partners had decreased from 52 in 2009 to 42 in 2014. The GP partners believed this to be a very positive change and helped assure the future of the practice.

Members of staff we spoke with all knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these.

**Governance arrangements**

There was a clear leadership structure with named members of staff in lead roles. For example, a GP was the lead for infection control and another GP was the lead for safeguarding. All clinical staff had clear lines of responsibility and accountability. Administration and support staff also had clear lines of accountability and supervision. Members of staff we talked with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had a number of policies and protocols in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 12 of these policies and protocols and saw they had been regularly reviewed and updated where appropriate.

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

The GPs told us about a local peer review system they took part in with neighbouring GP practices. One of the GPs was the CCG lead for the 'twinning' initiative which allowed the practice the opportunity to measure its service against others and identify areas for improvement. The program had now ended although the practice was still working in partnership with neighbouring practices continued through the monthly CCG locality meetings.

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

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

**Leadership, openness and transparency**

We saw from minutes that various meetings were held regularly, including partners meetings and weekly practice meetings and nursing /healthcare assistant meetings. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Minutes from these meetings showed that new initiatives and updates were discussed and had resulted in the healthcare assistants developing additional competencies in such areas as wound care, spirometry and ear irrigation.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and the management of sickness which were in place to support staff. We were shown the staff handbook that was given to all staff, which included sections on equality and harassment and bullying at work. The handbook and policies were also available to all staff on the practice computer system. Staff we spoke with knew where to find these policies if required.

**Seeking and acting on feedback from patients, public and staff**

The practice had gathered feedback from patients through patient surveys. The last survey had received 305

# Are services well-led?

Good

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

responses. We saw that the practice had taken due regard of the results of the survey, for example by carrying out an audit of response times to telephone calls and a planned strategy meeting to reassess access to the practice.

We saw the results of a short patient survey undertaken in September and October 2014 in which 100 patients attending the practice had been asked five questions. We noted that 87% of patients would recommend the practice to family and friends.

The practice had an active patient participation group (PPG) whose committee consisting of ten active members met regularly. The Chair of the group told us the make-up of the committee was reflective of the patient demographic. The PPG had been instrumental in organising an open day on a Saturday to allow patients to see how a practice worked and primarily to try and educate patients about the impact high rates of not attending appointments had on the practice and other patients.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

**Management lead through learning and improvement**

The practice held weekly educational meetings at the practice for staff which consisted of the presentation of relevant topics identified as practice GP learning needs and a review of local and national guidelines, including new developments.

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

The practice had completed reviews of significant events and other incidents and shared any learning with staff though the various meetings held at the practice to ensure improved outcomes for patients.

The practice was a GP training practice and had been so since 2011 and had three GP trainers. The practice had also been successful in being accepted as a final year medical student practice for Imperial College, London.