Asquith Surgery

Quality Report

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

Ratings

Overall rating for this service	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Asquith Surgery on 12 July 2017. Overall, the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting, recording and reviewing significant events.
- The practice had systems to minimise risks to patient safety.
- Prescription forms and pads were stored securely and patients receiving high risk medicines were regularly reviewed.
- Staff were aware of current evidence based guidance and their training had provided them with the skills and knowledge to deliver effective care and treatment. There was also a focus on ongoing learning and training to maintain and develop skills.
- The practice aimed to provide patient centred care taking into account patients' needs, circumstances and preferences.
- Results from the national GP patient survey were comparable with local and national averages and showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain or raise concerns was available. Improvements were made to the quality of care because of complaints and concerns.
- Patients who commented on their care described the service as good and said they were treated as individuals. They said they found it relatively easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- 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.

Summary of findings

- The patient participation group was actively involved with the practice, for example ensuring that information in the waiting room was kept up to date.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The provider had taken its role in caretaking the practice seriously and had supported staff and tried to improve the service. For example, it had increased the numbers of NHS checks undertaken from 17 to 285 over a 12 month period, and carried out a project to identify those patients who would benefit from an advance care plan and provided these.
- Several patients and the patient participation group felt the practice had improved during the caretaking period.

There were areas where the provider should make improvements:

The practice should ensure that all significant events discussed at the weekly clinical meetings are also documented in the significant events folder to ensure that any trends are identified and learning shared with all staff.

The practice should ensure that staff continue to undertake clinical audits and quality improvement.

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.

- From the documented examples we reviewed, we found there was an effective system for reporting, recording, and reviewing most significant events. However the practice needed to ensure that any significant incident discussed at weekly clinical meetings were also recorded in the significant events folder to ensure that lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong, patients were informed as soon as practicable, received reasonable support, information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- The last data from the Quality and Outcomes Framework (QOF) published in October 2016 related to the previous provider. The practice shared with the inspection team the unpublished data it had submitted to QOF which showed the practice had improved patient outcomes.
- We found that staff were aware of current evidence based guidance and used this to ensure effective treatment.
- Staff had started to undertake some clinical audit. The practice should ensure clinical audits are undertaken on a continuing basis to demonstrate quality improvement
- Staff were skilled and had the knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Summary of findings

- End of life care was personalised and coordinated with other services involved. There were regular meetings and discussions with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Comments made on the CQC feedback cards reflected the positive experiences many patients had.
- The practice had identified 84 patients (or 2% of its list) with caring responsibilities. Carers were able to see or speak to a clinician on the same day. Information for patients about the services available was accessible in the waiting area and on the website.
- We saw staff knew many patients well and treated them with kindness and respect, and maintained patient and information confidentiality.
- The practice identified patients who could benefit from referral to a local care navigator service to help them continue to be able to live in their own homes and with their consent referred them.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, several members of staff spoke community languages. Travel vaccinations were available which patients visiting the Indian sub-continent found particularly useful.
- The practice had introduced INR testing for patients needing anti-coagulation therapy at the practice which meant that patients no longer had to go to hospital clinics for this.
- Patients we spoke with said they found it relatively easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared in order to encourage improvement.

Summary of findings

- Staff were aware that, for example patients with visual impairment or restricted mobility sometimes found it difficult to find their way around the building. They would therefore escort the patient to ensure they went to the right room.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients and had worked with existing staff in the practice to do this.
- There was a clear leadership structure and staff felt well supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- A member of the patient participation group told us that they felt that staff morale had improved during the caretaking period.
- A governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff training had been updated. Staff had received annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour.
- The partners and managers encouraged a culture of openness and honesty. The practice had systems in place to ensure staff were aware of notifiable safety incidents and alerts and ensuring appropriate action was taken.
- The practice sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels.
- Weekly clinical meetings provided peer review and support for all clinical staff.

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.

- The practice told us that they treated their older patients with care, respect and dignity and offered proactive, personalised care to meet their needs.
- The practice had written to all their patients over 65 informing them of the named accountable GP responsible for their care. This helped to ensure continuity of care.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs, and when necessary arranged urgent home visits from the crisis response team (CRT)
- The provider had realised that relatively few patients had advanced care plans in place and had employed a specialist advanced nurse practitioner (ANP) to review this. Patients and their families or carers were contacted and offered appointments. Where appropriate these took place in patient's homes at weekends. 106 patients were visited at home and by the end of the project over 138 advanced care plans had been put into place. This work was then continued by the permanent staff.
- The practice was able to identify older patients who might need palliative care as they were approaching the end of life and involved patients families and carers in decisions about this.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any changes to their care or medicines.
- Staff were able to recognise the signs of abuse in vulnerable older patients and knew how to escalate any concerns.
- Staff knew many of the patients well and if concerned about them, for example, if they had become confused raised this with the clinical staff to help ensure care and support.
- Where older patients had complex needs, the practice shared summary care records with local care services. The practice held regular multi-disciplinary meetings where the needs of patients, for example, receiving end of life care were discussed.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. Patients were referred tolocal health and social care coordinators ('Care Navigator') which provided practical support and advice to help people in live as independently as possible in their own homes.

Summary of findings

People with long term conditions

Good

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

- The practice had identified patients at risk of hospital admission and alerts on their records ensured same day contact with a GP and home visits where necessary.
- Nursing staff had lead roles in long-term disease management such as Chronic Obstructive Pulmonary Disease and were supported by the GPs and specialist nurses.
- The practice had started providing blood tests for patients who needed anti-coagulation therapy. Previously patients had to attend hospital based clinics for this.
- When patients with long-term conditions were discharged from hospital the practice reviewed their care plans and ensured they were updated to reflect any changed needs such as medicines.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- There was a system to recall patients for a structured annual review to check their health and medicines needs were being met. Where possible patients with multiple long-term conditions were invited for one appointment to review all the conditions.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice referred patients to health and social care coordinators for support to live independently in their own homes.

Families, children and young people

Good

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

- The practice had systems in place to identify children who might be vulnerable, for example, those who had a high number of accident and emergency attendances, or who did not keep appointments, and reviewed these cases, taking appropriate action where necessary.
- Immunisation rates were relatively high for all standard childhood immunisations. The practice contacted parents who had not attended.
- Children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Summary of findings

- The practice provided 24 hours baby checks and 6 week post-natal assessments which included family planning advice.
- The practice provided support for premature babies and their families before and following discharge from hospital.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of antenatal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications. Clinicians were aware of guidance to help identify and treat sepsis.

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 practice had taken into account the needs of these patients and had adjusted the services it offered to ensure these were accessible flexible and offered continuity of care. It offered, for example, extended opening hours on Thursday and Friday mornings from 7am.
- The practice offered pre-bookable telephone consultations which working people found useful.
- The practice had developed online services, for example repeat prescribing and on-line booking which had not previously been available.
- The practice had realised that few NHS health checks had previously been offered and had worked with the PPG to encourage take-up of these, increasing the number done from 17 to 285 over a 12 month period.
- The practice offered smoking cessation advice and referrals, and alcohol/drug abuse service referrals

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 carers, and those with a learning disability.
- People who were homeless were directed to a local primary care service specifically designed for homeless people

Summary of findings

- The practice delivered end of life care in a coordinated way which took into account the needs of those whose circumstances made them vulnerable.
- The practice offered longer appointments for patients with a learning disability and for those with mobility problems.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations and where appropriate referred them directly.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- Staff were able to describe situations where they had had concerns for patients and took action to keep them safe.

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).

- Patients at risk of dementia were identified and offered an assessment.
- 91%
- The practice specifically considered the physical health needs of patients with poor mental health and dementia, for example, offering regular health checks and medicines reviews.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice had achieved maximum QOF results for its treatment of patients with mental health issues.
- 90% of patients living with dementia had received a face to face review in the previous 12 months.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice referred patients with poor mental health to a variety of services which provided counselling, cognitive behavioural therapy and advice and listening. It worked closely with the local mental health coordinator
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.

Summary of findings

- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia, for example, by offering longer appointments with the patient's regular GP unless in an emergency.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017 and related to January – March 2017. 292 survey forms were distributed and 107 were returned. This represented a 37% return rate and 2.7% of the practice's patient list. The results showed the practice was performing in line with local and national averages.

- 83% of patients described the overall experience of this GP practice as good compared with the CCG average of 77% and the national average of 85%.
- 84% of patients described their experience of making an appointment as good compared with the CCG average of 63% and the national average of 73%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 67% and the national average of 77%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were all positive about the standard of care received. Patients noted improvements had been made during the caretaking period and said they felt that everyone, from reception staff to the GPs provided an excellent service and that staff were friendly, helpful, polite and caring.

We spoke with five patients during the inspection. All said they were satisfied with the care they received and thought staff were friendly and caring. The practice's friends and families test results showed that over the previous 12 months 100% were likely or very likely to recommend the practice to family and friends.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that all significant events discussed at the weekly clinical meetings are also documented in the significant events folder to ensure that any trends are identified and learning shared with all staff.

The practice should ensure that staff continue to undertake clinical audits and quality improvement

Asquith Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and included a GP specialist adviser and a practice manager specialist advisor.

Background to Asquith Surgery

Background to Asquith Surgery

The Asquith Surgery is located at 693 Welford Road Leicester LE2 6FQ, near the border between Leicester City and Leicestershire. The Asquith Surgery was a long established practice until 2014 when the provider retired.

The practice then had a two different providers during the next two years. In April 2016, the practice went into an emergency caretaking arrangement at short notice. As the CCG explained to us, 'Emergency caretaking is a short to medium term solution whereby a provider is identified to manage, i.e. care take, a GP practice whilst a permanent solution is found.'

In this case the provider that took on the care taking contract was Fosse Medical Practice. They explained to the inspection team that as the initial contract was for six months their initial aim was to maintain the service and where possible improve it. They also felt that it was very important to work with and support the existing staff. The care taking contract was extended for two further six month periods and will have been for 18 months when it ends on 30 September 2017. Fosse Medical Practice did not bid for the future contract.

The surgery is housed in a two-storey detached property, which was formerly a domestic property and is owned by NHS Estates. It has automatic entrance doors, a disabled parking space and on street parking. Patients with mobility problems are offered longer appointments and are seen in downstairs consulting rooms. The waiting area is separated from the reception desk and there are on-screen announcements of appointments.

- There is a salaried male GP who works for ten sessions a week and a long-term female locum GP who works for eight sessions per week. A GP partner from the provider spends a minimum of two sessions a week at the Asquith Surgery to see patients and support staff.
- The practice nurse and health care assistant are female and work 75% and 50% of the week respectively.
- There is a range of support staff including receptionists, a practice manager and assistant practice manager.
- The practice is open between 8am and 6.30pm Monday to Friday. Routine appointments are from 9am to midday and 3pm to 6pm. The duty doctor is available from 8am to 6.30pm. Extended hours appointments are offered from 7am on Thursday and Friday mornings with a GP or nurse.
- Out of hours services are provided by Derbyshire Health United (DHU) via the NHS 111 telephone number.
- Patients registered with Leicester City practices can also access (initially by telephone) three 'Healthcare Hubs' (located at health centres/GP practices in the city) during evenings and weekends.
- The number of patients registered with the practice is 4,000 and this had increased by about 3% over the previous 12 months.
- Some patients live within the Leicester city boundary and others are within Leicestershire which can create some difficulties when arranging social care and support.
- 50% of the practice's patients are White British and 30% are Asian or Asian British.

- 9% of the practice's patients are aged over 75 years which is twice the CCG average.
- Social and economic deprivation is relatively low.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

How we carried out this inspection

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. Published QOF (Quality Outcomes Framework) related to a period before the provider took on the caretaking role. The practice provided us with data it had given to the CCG for the April 16 – 17 period.

We carried out an announced visit on 12 July 2017. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members where possible.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population 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 living with dementia).

There was limited information available about the practice's performance, for example, the most recently published QOF (quality outcome framework) data was for the year 2015-16 which was before the current provider started the caretaking contract for the practice. The current provider provided the inspection team with QOF data it had submitted to the CCG and NHS England.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and they completed the form available to document it.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From a sample we reviewed we found that when things went wrong with care or treatment, patients were informed as soon as reasonably practicable, received support, information, a written apology (where appropriate) and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. We noted that the weekly clinical meetings included significant events as a standard item but not all of these were also recorded in the significant events folder so the practice may have missed the opportunity to share any learning identified with all staff.
- All patient safety alerts (including from the Medicines and Healthcare products Regulatory Authority (MHRA) were received by the senior partner and the practice manager who arranged for patient record searches to identify any patients potentially affected. They were then discussed at the weekly clinical meetings and actions decided on. We checked a sample of recent alerts and, for example, we saw one that related to a medicine used to treat urinary problems had been actioned appropriately.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For, example, patients with mobility problems were always seen in ground floor rooms and also offered longer appointments to take into account their needs and the time it might take to move around the building.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding children and vulnerable adults reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding and safeguarding was an agenda item at the weekly clinical meetings. We saw examples of safeguarding referrals that had been made. GPs provided reports where necessary for other agencies and ensured alerts were placed on the record system for both children and vulnerable adults. The practice also kept a safegarding register of vulnerable adults and children. The practice had developed good working relationships with health visitors and school nurses and shared any concerns with them.
- Staff interviewed had received training on safeguarding children and vulnerable adults relevant to their roles. They could explain their responsibilities regarding safeguarding. They were able to describe situations where they had raised concerns about a patient and what action had been taken. GPs were trained to child protection or child safeguarding level three and attended training updates.
- A notice in the waiting room and in other areas advised patients that chaperones were available if required. All clinical staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Some reception staff also acted as chaperones and had been trained but not DBS checked. The practice had undertaken a risk assessment which stated that these staff would not act as chaperones for children or vulnerable adults such as those with mental health problems or learning disabilities and that they would never be left alone with any patient. Staff we spoke with understood this They also understood that they were never to be left alone with any patient.

Good

Are services safe?

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. Cleaning schedules were in place and these were monitored by the practice manager or assistant practice manager.
- The practice manager and practice nurse shared responsibility for infection prevention and control (IPC) The practice nurse checked all clinical areas and the practice manager had undertaken an infection control audit and ensured that action was taken to address any improvements identified. There was an IPC protocol and staff had received up to date training.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Processes for handling repeat prescriptions included, for example, checking that appropriate blood tests had been obtained before high-risk medicines such as warfarin and methotrexate were prescribed.
- The practice carried out regular medicines audits, with the support of the local clinical commissioning group medicines management team, to ensure prescribing was in line with best practice guidelines.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow the nurse to administer medicines in line with legislation. The health care assistant was trained to administer vaccines and medicines and patient specific directions from a prescriber were produced appropriately.

We reviewed three personnel files which contained evidence of qualifications and registrations with the appropriate professional bodies, references, qualifications, and appropriate checks through the DBS. (Disclosure and Barring Service) (these checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Although no new staff had been employed since the provider had taken on the caretaking role, the provider had reviewed all personnel files and ensured, for example, that they contained information about registration with relevant professional bodies and records of training done.

The provider's recruitment policy showed that appropriate checks would be undertaken before any new staff were employed.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available and a health and safety poster was displayed.
- The practice had an up to date fire risk assessment and had carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- Records showed that all electrical and clinical equipment was checked and calibrated to ensure it was safe to use and in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health (COSHH) and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.

Good

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks which were checked regularly. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and suppliers. If necessary, the practice could access this and patient recordsat the provider's main location.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE via the practice intranet and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through random sample checks of patient records, peer reviews and regular discussion at the weekly clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (from October 2016) related to the previous provider but the current provider was able to show the inspection team the practice's results from April16/17 which it had submitted. These showed that the practice had scored 99% which was an increase of 3% from the previous year's results.

The practice had found that few patients aged 40 – 75 had previously been offered NHS health checks and had made this a priority. It had done 285 health checks in a 12 month period compared with 17 which had been done in the 12 months before it it took over.

Since the caretaking arrangement began in April 2016 there was evidence of quality improvement including some clinical review and audit, for example, related to care plans.

- There had been one completed clinical audit in this period which showed that improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, patients who were prescribed warfarin but who were out of the therapeutic range were reviewed and prescribed newer anti-coagulants after discussion with the GP.
- As a result of this audit, the practice initiated anticoagulant medicines for patients at the surgery rather than referring them to hospital clinics as had previously been the case.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This was kept under review using feedback from staff and covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, those reviewing patients with long-term conditions such as chronic obstructive pulmonary disease (COPD) attended regular updating training.
- The member of staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence. They kept up to date with changes to the immunisation programmes, for example, by attending training, accessing on line resources and discussion at practice meetings.
- The provider had introduced a system of appraisals, meetings and reviews of practice development needs which also identified training needs. Staff told us that appreciated being involved in these processes and that they felt encouraged and supported to develop new skills. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- Staff had received a variety of training that included safeguarding, fire safety awareness, and basic life support, dementia awareness and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

Relevant staff had timely access to the information they needed to plan and deliver care and treatment through the practice's patient record system and their internal computer system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The provider had found that the Clinical Commissioning Group (CCG) target of 80 patients having advanced care plans in place was not being met. They decided to employ an advanced nurse practitioner (ANP) on a temporary contract to improve this. The ANP had made home visits, frequently at weekends, to identified patients to discuss and complete advanced care plans, where possible involving relatives and carers. This had resulted in 138 advanced care plans being put into place.
- From the examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services. The practice used a system called PRISM (patient referral medical information) purchased by the CCG to help ensure coordination and good practice.
- Summary care records were available to out of hours services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record.

- Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those whose circumstances made them vulnerable.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- < >taff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Clinicians had completed training related to this and the Deprivation of Liberty safeguards.
  When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through reviews of patient records and any issues were discussed during weekly clinical meetings.

Supporting patients to live healthier lives

The practice identified patients who were in need of extra support and signposted them to relevant services. For example:

- Patients who were experiencing difficulties in their home environment were referred to a local social care and support services, which provided practical help and support to help people live safely in their own home. The service was provided by the local authorities and the CCG.
- Patients were also referred to the local 'Health Trainer' service for advice and practical support with smoking cessation, dietary advice, and generally achieving a healthier lifestyle.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/ national averages. For example, rates for the vaccines given to under two year olds ranged from 93% to 100% and five year olds from 92% to 93%.

Good

Are services effective?

(for example, treatment is effective)

- The practice's uptake for the cervical screening programme was 79%, which was comparable with the CCG average of 78% and the national average of 81%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice ensured there was a female sample taker available and worked with the carers of people with learning disabilities to encourage uptake of this test. The practice followed up women who were referred as a result of abnormal results and also had systems in place to check that results were received for all samples sent.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. 75% of females aged 50 to 70 had attended for breast cancer screening in the last 36 months, which was similar to the CCG and national average of 73%.

40% of patients aged 60 to 69 had attended for bowel cancer screening in the last 30 months, which was similar to the CCG average of 45% but below the national average of 58%. The CCG was planning a local initiative to improve these rates which would involve GPs contacting patients to encourage them to have the screening test. The practice welcomed this initiative and planned to be fully involved with it.

The practice actively promoted appropriate health assessments and checks through posters, on its website and when patients visited the surgery. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice had increased the number of NHS health checks from 17 to 285 over a 12 month period and also offered these for all new patients in the relevant age group. There were appropriate follow-ups for the outcomes of health assessments and checks where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE via the practice intranet and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through random sample checks of patient records, peer reviews and regular discussion at the weekly clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (from October 2016) related to the previous provider but the current provider was able to show the inspection team the practice's results from April16/17 which it had submitted. These showed that the practice had scored 99% which was an increase of 3% from the previous year's results.

The practice had found that few patients aged 40 – 75 had previously been offered NHS health checks and had made this a priority. It had done 285 health checks in a 12 month period compared with 17 which had been done in the 12 months before it it took over.

Since the caretaking arrangement began in April 2016 there was evidence of quality improvement including some clinical review and audit, for example, related to care plans.

- There had been one completed clinical audit in this period which showed that improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, patients who were prescribed warfarin but who were out of the therapeutic range were reviewed and prescribed newer anti-coagulants after discussion with the GP.
- As a result of this audit, the practice initiated anticoagulant medicines for patients at the surgery rather than referring them to hospital clinics as had previously been the case.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This was kept under review using feedback from staff and covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, those reviewing patients with long-term conditions such as chronic obstructive pulmonary disease (COPD) attended regular updating training.
- The member of staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of competence. They kept up to date with changes to the immunisation programmes, for example, by attending training, accessing on line resources and discussion at practice meetings.
- The provider had introduced a system of appraisals, meetings and reviews of practice development needs which also identified training needs. Staff told us that appreciated being involved in these processes and that they felt encouraged and supported to develop new skills. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff had received a variety of training that included safeguarding, fire safety awareness, and basic life support, dementia awareness and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

Good

Are services caring?

Relevant staff had timely access to the information they needed to plan and deliver care and treatment through the practice's patient record system and their internal computer system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The provider had found that the Clinical Commissioning Group (CCG) target of 80 patients having advanced care plans in place was not being met. They decided to employ an advanced nurse practitioner (ANP) on a temporary contract to improve this. The ANP had made home visits, frequently at weekends, to identified patients to discuss and complete advanced care plans, where possible involving relatives and carers. This had resulted in 138 advanced care plans being put into place.
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Are services caring?

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Are services caring?

Good

I

Our findings

Kindness, dignity, respect and compassion

During our inspection, we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs. The reception area was relatively private as it was separated from the waiting room with glass doors and partitions.
- Patients could be treated by a male or female GP.

All of the 27 Care Quality Commission patient comment cards we received were positive about the service experienced. Patients said they felt that everyone, from reception staff to the GPs provided an excellent service and that staff were helpful, polite and caring.

We spoke with five patients including a member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They also noted that the service had improved during the caretaking period. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2017 showed patients felt they were treated with care, dignity and respect. The practice's scores were comparable with local averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 79% of patients said the GP gave them enough time compared with the CCG average of 83% and the national average of 86%.
- 96% of patients said they had confidence and trust in the last GP they saw compared with the CCG average of 93% and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared with the local average of 81% and national average of 86%.
- 96% of patients said the nurse was good at listening to them compared with the CCG average of 87% and the national average of 91%.
- 91% of patients said the nurse gave them enough time compared with the CCG average of 88% and the national average of 92%.
- 98% % of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 96% and the national average of 97%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the local average of 96% and national average of 97%.
- 88% of patients said they found the receptionists at the practice helpful compared with the CCG average of 80% and the national average of 87%.

Good

Are services caring?

The practice had noted that the survey results had improved from previous surveys but it also worked with the PPG which encouraged patients to complete feedback questionnaires. These included questions about the ease of making appointments, how patients felt they were treated by clinicians and other staff and whether patients would recommend the practice to others. Responses helped the practice focus on how it could make improvements.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised and used information provided by the patient and carers.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example,

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the local average of 77% and national average of 82%.
- 95% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 88% and the national average of 90%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 82% and national average of 85%

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation 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. Patients were also told about multi-lingual staff that might be able to support them.
- Information leaflets were available in easy read formats and in several community languages.
- The electronic referral service (ERS) was used with patients as appropriate. (ERS has replaced the Choose and Book service. It is a national electronic referral service, which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)

Patient and carer support to cope emotionally with care and treatment

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Support for isolated or housebound patients included signposting to relevant support and volunteer services and where appropriate a referral to a local Care Navigator service which supported people to remain in their own homes.
- The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 84 patients as carers (2% of the practice list) and there was information available at reception and in the waiting area about local support services available. The patient participation group ensured this was up to date.
- Staff were encouraged to be aware of situations where elderly patients were in caring roles and might need support, for example, from the Care Navigator service.
- Older carers were offered timely and appropriate support, for example, flu and other appropriate vaccinations and annual health checks.
- Staff told us that if families had experienced bereavement the practice normally sent them a sympathy card which also included information about local support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population. The practice had a good understanding about the age, ethnicity and deprivation factors affecting its patients. For example 50% of the patient group were white and 30% had a were British Asian. Nine per cent of its patients were aged over 75 which was twice the local average.

- The practice offered extended hours on Thursday and Friday mornings from 7am primarily for working patients who could not attend during normal opening hours. GP and nurse appointments were available.
- Patients were also able to access three Healthcare 'Hubs' providing GP services to patients registered with GPs in Leicester City. These were generally open until 8pm. Information about how to access the Hubs was available at the surgery and on its website.
- There were longer appointments available for patients with a learning disability and for patients with mobility problems.
- Home visits were available for older patients and patients who had clinical needs that resulted in difficulty attending the practice.
- Requests for urgent home visits were assessed by a GP and if it was felt an urgent visit was needed early in the day which the practice could not do it contacted the crisis response team (CRT) which is a paramedic led service funded by the Clinical Commissioning Group (CCG).
- The practice was aware of those patients who had life-limiting progressive conditions potential end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that required a same day consultation.
- The practice sent text message reminders of appointments.
- Patients were able to receive travel vaccines available on the NHS. Patients were referred to other clinics for vaccines only available privately.
- There were accessible facilities, which included a hearing loop and disabled parking. Interpretation services were available and clinical and support staff spoke a range of community languages.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 9am to midday every morning and 3pm to 6pm every afternoon. The on-call doctor was available from 8am to 6.30pm Monday to Friday. Extended hours appointments were offered on Thursdays and Fridays from 7am. Pre-bookable appointments could be booked up to six weeks in advance, and same day appointments were available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than most local national averages.

- 85% of patients were satisfied with the practice's opening hours compared with the CCG average of 74% and the national average of 76%.
- 73% of patients said they could get through easily to the practice by phone compared to the CCG average of 59% and national average of 71%.
- 89% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 76% and the national average of 84%.
- 86% of patients said their last appointment was convenient compared with the CCG average of 73% and the national average of 81%.
- 84% of patients described their experience of making an appointment as good as compared with the CCG average of 63% and the national average of 73%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them and often on the day or next day.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Reception staff used their guidance and training to obtain relevant information about the patient's condition and passed this to the on-call GP who would telephone the patient to discuss their problem. In cases where the urgency of need was so great that it would be

Good

Are services responsive to people's needs?

(for example, to feedback?)

inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, there was a leaflet that asked patients to give feedback and complain if they wished to.
- Reception staff told us that that if they were aware that a patient was unhappy they asked if they wanted to discuss the matter with them or with the practice manager.

We looked at two complaints received in the last 12 months as well as a summary of complaints. We found that lessons were learned from individual concerns and complaints and from analysis of trends and that action was taken to as a result to improve the quality of care. Staff told us they were comfortable about raising any area of concern or complaint, as they knew it would be treated as an opportunity for learning.

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 provider had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a clear strategy and supporting business plans that reflected the vision and values and were regularly monitored.
- It had also identified areas where improvements were needed to help ensure the new provider had appropriate management information. For example, the practice had created a cental training matrix which showed what training staff had received and when it needed to be updated.

Governance arrangements.

The practice had a governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs had lead roles in key areas, for example, safeguarding.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- The provider had kept the practice performance under review during the caretaking period and had encouraged the GPs employed at the practice to undertake clinical audits to improve quality and make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The practice manager monitored checks done by the landlord (NHS Properties) relating to the safety of staff and patients, for example, related to legionella and COSHH (control of substances hazardous to health).
- We saw evidence from minutes that the practice had a meetings structure that allowed lessons to be learned and shared following significant events and complaints. However, it appeared that some significant events discussed at clinical meetings were not also recorded in the significant events folder so that learning was not always shared with all staff
- Staff told us they felt comfortable raising any issues or concerns at these meetings.

Leadership and culture

On the day of inspection, the partner and practice manager from the caretaking practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partner, GPs and managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment the practice gave patients information, support and where appropriate a verbal and written apology.

- The practice encouraged staff to record any verbal complaints or concerns so the practice could learn from these as well as from complaints raised formally.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs regularly met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.

Are services well-led?

Good

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

- Staff said they felt respected, valued and supported, particularly by the partners and manager in the practice and they felt comfortable and supported to raise any issues at team meetings or with the practice manager.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, reviewed the results of patient surveys and submitted proposals for improvements to the practice management team. For example, the practice had installed a new telephone system following feedback about the difficulties patients experienced getting through to the practice. There had been positive feedback from patients about the new system.
- The NHS Friends and Family test, complaints and compliments received and an annual patient survey carried out by the PPG.
- Staff through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

Continuous improvement

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The provider had been committed to improving the practice and staff morale throughout the caretaking period.