

Dr S M Arolker and Partners

Quality Report

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

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 Dr S M Arolker and Partners on 16 July 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. 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.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it difficult to make an appointment with a named GP but urgent appointments were 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.

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

Importantly the provider should:

- Consider improved ways to deliver effective multi-disciplinary working in relation to safeguarding and palliative care patients.
- Ensure a whistleblowing policy is in place and that staff know how to access it.
- Ensure the defibrillator at Parker Drive is accessible to staff at all times.

Summary of findings

- Ensure that reception staff know how to act appropriately when patients with urgent treatment needs contact the surgery, for example breathlessness.
- Ensure action plan for learning disability reviews is monitored through the practice meetings.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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 patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed most patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Staff worked with multidisciplinary teams although no recent meetings had taken place. The multi-disciplinary meetings had been set up to commence monthly.

Good



Are services caring?

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

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it difficult to make an appointment with a named GP but urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs although there was limited access for

Good



Summary of findings

disabled patients at Parker Drive Medical Centre. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy although staff were not 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 although some of these needed to be reviewed and updated. The practice held regular 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.

Good



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

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 for those with enhanced needs.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The multi-disciplinary meetings had been set up to commence monthly.

Good



Families, children and young people

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

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible. Saturday morning appointments were available at each surgery on alternating weeks. 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.

Good



Summary of findings

People whose circumstances may make them vulnerable

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 however the practice recognised there was a poor uptake. They offered the option of home visits or a Saturday morning appointment to try and increase the uptake and had put together an action plan to improve. It offered longer appointments for people with a learning disability.

The practice regularly communicated 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.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 90% of people with dementia had received an annual review. It carried out advance care planning for patients with dementia. 67% of people with poor mental health had their care plans reviewed in the last year.

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

Good



Summary of findings

What people who use the service say

We spoke with 18 patients during our visit.

We asked the practice to put out a box and comment cards in reception where patients and members of the public could share their views and experiences. We reviewed 13 comment cards and they were generally positive about the service experienced. Patients said they were able to get an appointment with the GP on the same day if urgent. They told us they felt the practice offered an excellent service and staff were helpful, professional and caring.

Patients said that the practice was clean.

We looked at the results of the January 2015 national patient survey. 339 forms had been distributed to patients. 95 had been returned and completed which was 28% of those distributed.

We saw the results of the Friends and Family Test for the months of January to June 2015. 71 had been completed and 77% said they were either extremely likely or likely to recommend the practice to friends or family.

Areas for improvement

Action the service SHOULD take to improve

Action the provider SHOULD take to improve:

- Consider improved ways to deliver effective multi-disciplinary working in relation to safeguarding and palliative care patients.
- Ensure a whistleblowing policy is in place and that staff know how to access it.

- Ensure the defibrillator at Parker Drive is accessible to staff at all times.
- Ensure that reception staff know how to act appropriately when patients with urgent treatment needs contact the surgery, for example breathlessness.
- Ensure action plan for learning disability reviews is monitored through the practice meetings.

Dr S M Arolker and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and two additional CQC inspectors and a variety of specialists: a practice nurse, a practice manager, an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Dr S M Arolker and Partners

Dr S M Arolker and Partners provides primary medical services to a population of approximately 15,000 registered patients in Leicester. Parker Drive Medical Centre is the main surgery and is located at 122 Parker Drive, Leicester. It also has a branch surgery, Manor Medical Centre which is located on Melton Road, Thurmaston, Leicester.

Parker Drive Medical Centre serves Beaumont Leys, Stocking Farm, Mowmacre Hill and the Stadium Estate. There is a higher than average unemployment rate and areas of high deprivation.

Manor Medical Centre is located on the Thurmaston Village and Leicester Border. Manor Medical Centre provides a service to different ethnic groups, including Indian/Asian population.

The practice had a General Medical Service contract (GMS). The General Medical Services (GMS) contract is the contract between general practices and NHS England for delivering primary care services to local communities.

We inspected both the branch and main practice at this inspection.

The practice is currently operated by six GP partners (five male and one female). The practice also has one advanced nurse practitioner, three nurses, three health care assistants (HCA's) and two phlebotomists. The staff rotate between the two sites. The Parker Drive surgery has a practice manager, two data clerks, two admin clerks and four reception staff. The Manor Medical surgery has a practice manager, a secretary, two data clerks and six reception staff.

The practice is located within the area covered by NHS Leicester City Clinical Commissioning Group (CCG). A CCG is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Parker Drive is a two level practice, with limited access for disabled patients and car parking facilities. Manor Medical is on two floors, has a lift for disabled access to the clinic rooms on the second floor and a large car park. The surgery is open 8.00am to 6.30pm Monday, Tuesday, Wednesday and Friday. On Thursdays the Parker Drive Medical Centre is open 8.00am to 1.00pm. The practice offers a Saturday morning surgery with urgent and pre-booked appointments between 8.00am and 1.00pm alternating between the two surgeries.

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

Parker Drive Medical Centre 122 Parker Drive, Leicester.

Branch surgery, Manor Medical Centre, Melton Road, Thurmaston, Leicester.

Dr S M Arolker and Partners has opted out of providing out-of-hours services (OOH) to their own patients.

Detailed findings

Out-of-Hours services are provided through Leicester, Leicestershire and Rutland Out-of-Hours Service. This is provided by Central Nottinghamshire Clinical Services. Patients can access this service via the NHS 111 service.

The practice was previously inspected by the Care Quality Commission on 16 July 2014 however it did not receive a rating at that time.

Why we carried out this inspection

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

This provider had been inspected by the Care Quality Commission in 2014. They did not receive a rating. They were in breach of Regulation in relation to Management of medicines so we have re-inspected this location to check that improvements have been made and to give the practice a rating for the services they provide.

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

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

- Older people
- People with long-term conditions
- 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 and asked other organisations to share what they knew. We carried out an announced visit on 16 July 2015 at both the main surgery and the branch. During our inspection we spoke with a range of staff and spoke with 18 patients who used the service. We reviewed 13 comment cards and letters where patients and members of the public shared their views and experiences of the service.

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

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example an incident had been recorded where a letter had been scanned onto the wrong patient, the action following this and shared learning of checking patient identifiers on all correspondence to prevent reoccurrence.

We reviewed safety records, incident reports and minutes of bi-monthly meetings where these were discussed. This showed the practice had managed these consistently over time and 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 five significant events that had occurred from April 2014 to May 2015 and saw this system was followed appropriately. Significant events were discussed at clinical meetings to review actions from past significant events and complaints however non clinical staff were not involved. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Reception and administrative staff received information about complaints and relevant outcomes either verbally or through notifications on the practice electronic computer system.

Staff completed paper incident forms and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared in the minutes of the clinical meetings.

National patient safety alerts were disseminated by email and notifications via the electronic computer system to practice staff. The system also highlighted if these notifications had been actioned by the staff member.

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, record safeguarding concerns and how to contact the relevant agencies in and out of normal working hours. Contact details for safeguarding concerns were easily accessible to all staff.

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 level three training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak within the practice if they had a safeguarding concern.

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.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff had criminal records checks through the Disclosure and Barring Service (DBS).

Medicines management

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, which described the action to take in the event of a potential failure. We saw that the practice staff followed the policy.

Are services safe?

Processes were not in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates however there was no documentation that showed when and how often the checks had taken place. The staff we spoke with were not aware of a process to tell them how to dispose of medication. Vaccine stocks received were not recorded with batch numbers and location which meant that if there had been an issue with a particular batch it would not be easy to identify any others in the same batch. We spoke with the Practice Manager about this and since the inspection the practice has put in place a process to record stock control including batch numbers and updated the medicines management process to include the disposal of expired and unwanted drugs. A practice meeting has also been held where this was discussed and implemented.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Blank prescription forms for use in printers were not removed when the rooms were not in use. We spoke to the practice manager about this and they have now put a process in place to remove them and to issue them at the start of each session. We saw that this had been communicated to all staff the day after our inspection.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

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

Cleanliness and infection control

We observed both the main surgery and the branch surgery to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The cleaner that was employed at Manor Medical Centre was on leave at the

time of our inspection but the practice staff had taken over the duties for that week. Patients said they always found the practice clean and had no concerns about cleanliness or infection control

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. Staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that an infection control audit had carried out last year and that any improvements identified for action were completed on time.

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.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example vaccine fridges, electrocardiogram (ECG) machines, pulse oximeters, nebulisers and spirometers.

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

Are services safe?

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. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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.

Locums were used in the practice and were requested through a locum agency. The agency provided paperwork that related to the GPs qualifications and legal requirements to work.

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 six monthly checks of the building and the environment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

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 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. The defibrillator at Parker Drive Medical Centre was at the time of our inspection accessible from a room on the second floor of the practice. We saw that when this room was not in use it was locked.

Not all the reception staff that we spoke with were not aware of a protocol for emergency situations over the telephone, for example shortness of breath. They told us that they would ask a colleague for advice on whether the patient should be seen on the same day or advise to call 999.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Hypoglycaemia is a low blood sugar. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. 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. For example, contact details of gas and water companies should the need arise.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that fire warden staff were up to date with fire training. The practice had regular fire drills and a full evacuation including patients took place in June 2015 with no issues identified.

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 (NICE) and from local commissioners.

The GPs told us that they had arrangements in place to discuss openly with each other if any practice was noted to be out of guidelines. 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 lead in specialist clinical areas such as diabetes, 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 open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. For example, in the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this took place.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. There had been previous concerns in relation to two week wait cancer referrals as they had previously been faxed. The practice had changed to electronic referrals where possible and urgent referrals were followed up with a telephone call by reception staff to ensure that the referral had been received.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need.

Management, monitoring and improving outcomes for people

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

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, following an incident that had been reported regarding a discharge letter which stated that medication had been stopped. This had not been actioned so a clinical audit was carried out. The aim of the audit was to ensure that all patients with hypertension were been monitored correctly. The information was shared with GPs and patients where necessary were called for a blood test and monitoring. A second clinical audit was completed two months later which identified a reduction in the amount of patients that still required monitoring. This was discussed as a team and increased the awareness of acting on discharge information.

Other examples of audits planned for the coming year included osteoporosis audit, antibiotic audit and other prescribing audits.

The GPs told us clinical audits were often linked to medicines management information, significant events, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of diazepam. 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. GPs maintained records which showed how they had evaluated the service and documented the success of any changes.

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was an outlier for QOF clinical targets in relation to seasonal flu vaccinations but was above national average in other areas. It achieved 96.7% of the total QOF target in 2014, which was above the national average of 93.5%. Specific examples to demonstrate this included:

- The practice performance for chronic obstructive pulmonary disease (COPD) related indicators was 100% which was 4.8% above the national average.
- Performance for hypertension QOF indicators was 99.4% which was 11% above the national average.
- The percentage of patients in the defined influenza clinical risk groups that received the seasonal influenza vaccination was 60.45%. This was below the national average of 73.24%.

The practice was aware of all the areas where performance was not in line with national or CCG figures. In relation to the influenza vaccinations the practice had planned a health promotion day in September for the upcoming flu campaign and had enlisted the help of the PPG to promote this (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). In addition to text message and letter reminders clinicians completed opportunistic vaccinations at routine appointments and Saturday morning appointments where available for patients that found it difficult to attend midweek.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients who received repeat prescriptions and ensured they had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The electronic patient record system flagged up relevant medicines alerts when the GP prescribed medicines.

The practice had a palliative care register but had not been holding regular meetings in relation to this.

The practice was part of a local federation with other practices in the area. This allowed information from the CCG to be looked at with a range of practices to look at

benchmarking. For example the CCG had looked at A&E admissions and reviewed admissions across the CCG. No particular learning had been gained for this practice other than ongoing education of patients.

This was a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The 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 one GP having an interest in cardiology and respiratory and another in dementia and minor surgery. 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). Locum GP's were provided with information in relation to their duties such as referrals information, practice clinics and safeguarding information and practice leads.

All staff undertook annual appraisals that identified learning needs from which action plans were documented.

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

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge

Are services effective?

(for example, treatment is effective)

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 had been an incident where a discharge summary had not been followed up appropriately and two letters per year were scanned onto the wrong patient electronic record in error. These errors had been picked up when clinical staff had reviewed the scanned letters. Issues had been recorded as a significant event and had been discussed with staff member concerned to prevent reoccurrence.

The practice had previously held multidisciplinary team meetings. However we were told that the last meeting had been in 2014 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 had not been in place for some time as it had been difficult to gain engagement with the district nurses, palliative staff and health visitors and midwives. In place of face to face meetings, the practice currently received communication from multi-disciplinary team members through the electronic computer system. Decisions about care planning were documented in a shared care record. Staff felt this system could be improved and realised the need for the multidisciplinary team meetings and were in the process of looking to restart these meetings.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local 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 fully 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.

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 with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

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) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us that 98% of care plans had been reviewed in the last year for patients with dementia. 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 understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check to all new patients registering with the practice. New patients currently on medication had to have a new patient appointment with a GP whilst those without current medication needs were booked in with a nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the

Are services effective?

(for example, treatment is effective)

GPs and nursing staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 45% of patients in this age group had taken up the offer of the health check so far. The practice also offered flu vaccinations to patients that were identified as a carer.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. The practice had 64 patients on their learning disability register. 25% had received a review last year. The practice had recognised that this was low and had addressed this with an action plan of steps that would be taken to ensure these patients were reviewed for example, the practice had identified a health care assistant who was telephoning all the patients on the list to arrange appointments, then the receptionist would telephone the day before to give a personal reminder. The practice had achieved 82% in 2013/14. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led

smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 72.6%, which was in line with the CCG average. There was a policy to offer text and letter reminders for patients who did not attend for cervical smears. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national mammography and bowel cancer screening in the area were all above average for the CCG (71.5% and 48.1% respectively), and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Childhood immunisation rates for the vaccinations given to under two year age group ranged from 86.1% to 99% and five year age group from 83.4% to 98.3%. These were in line with or above CCG averages ranging from 81.6% to 100% for under two year age group and 85.5% to 94.9% for the 5 year age group.

The practice also referred people to groups such as the Active lifestyles scheme and the Smoking cessation that was held in the practice each week.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey.

The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, data from the national patient survey showed the practice was generally in line with CCG and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 79% said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 85.7% and national average of 86.8%.
- 89.3% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 87.6% and national average of 91%.
- 72.7% said the GP gave them enough time compared to the CCG average of 82.6% and national average of 86.8%.
- 92.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 93.6% and national average of 95.3%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, professional and caring. They said staff treated them with dignity and respect. Three comments were less positive around the lack of appointments and the time waited for an appointment. We also spoke with 18 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 consultations and 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 where possible. The practice switchboard was located away from the reception desk at Manor Medical Centre and the waiting area was situated at the opposite end of the practice. The reception desk was wide enough to allow conversations to be held away from anyone at the other end of the desk. A sign had been introduced to ask patients to wait and allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. At Parker Drive Medical Centre we found that conversations at the reception desk could be overheard by the people in the waiting room. Reception staff we spoke with said that they were able to access a room if necessary for more personal conversations.

There was a clearly visible notice in the patient reception areas stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The January 2015 national patient survey information we reviewed showed patients responded poorly to questions about their involvement in planning and making decisions about their care and treatment and did not rate the practice well in these areas. For example,

- 75.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.3% and national average of 86.3%.
- 65.4% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77.2% and national average of 81.5%.

Patients we spoke with 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 generally felt listened to and supported by staff and had sufficient time during

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.

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. Staff we spoke with told us that they used an organisation in Leicester that were able to provide interpreters in advance or at short notice. The practice used this service when required. They also used the British Sign Language or Lip speaker who supported patients with a hearing disability. GP's and other staff in the practice were able to speak a range of languages. We saw one of the reception staff on our visit who we were told had translated for a patient in a consultation with a GP. One patient we spoke with that speaks Hindi and Gujarati told us 'the doctor can translate for me or speak my language. I am very happy here' another example was given of a Somali patient who could not speak any English. The practice arranged an appointment so that an interpreter from the centre could be there to interpret for the patient.

Patient/carer support to cope emotionally with care and treatment

The January 2015 national patient survey information we reviewed showed patients were not positive about the emotional support provided by the practice and rated it below average in this area. For example:

- 67.9% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80.1% and national average of 85.1%.
- 82.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86.1% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received differed from this survey information. For example, these highlighted that staff were caring and professional when they needed help and provided support when required.

Notices in the patient waiting rooms, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

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 patient'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. For example Saturday morning surgery was in place and alternated between the two surgeries. Appointments were available for patients that worked or where unable to access the practice midweek.

The NHS England 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.

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) such as alternating the Saturday morning clinics between the two sites, how reception staff handled calls and health promotion on the television screens in the waiting area. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. There was a high number of the practice population that were non English speaking patients and access to online and telephone translation services were available if they were needed. The practice had multi-lingual staff to help patients who spoke Gujarati, Punjabi or Hindi.

The premises at Manor Medical Centre had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as there was a lift to enable patient access to the first floor. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. At Manor Medical Centre we saw that some

patients had difficulty with a door that remained closed, due to it being a fire door. We spoke to the Registered manager about this and the practice had already identified the cost of an alternative system that would enable the door to be left open.

Whilst on inspection at Parker Drive Medical Centre we witnessed a patient that had an appointment on the first floor and visibly struggled to climb the stairs. This was discussed with the senior GPs and the practice manager who stated that this is not the normal procedure and that all receptionists know to offer the patient an appointment in one of the downstairs rooms if necessary. Following our inspection we were informed that this had being raised and investigated as a significant event and actions had being put into place. The practice had sent a letter of apology despite no complaint being received or made.

Staff told us that they did not have any patients who were of "no fixed abode" but would see anyone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice therefore patients could choose to see a male or female doctor.

Access to the service

Both surgeries were open from 8am to 6.30pm Monday to Friday. The surgery at Parker Drive was closed on Thursday from 1pm however the branch surgery Manor Medical Centre remained open. Appointments were available from 9.00am to 12.00 o'clock and 3.30pm to 6pm on weekdays. The practice ran a clinic every Saturday for urgent and pre-bookable appointments which alternated each week between the main and branch surgery. The last appointment time was 5.50pm on weekdays. The next available pre-booked appointment was in two weeks. Staff we spoke with told us that when patients contacted the practice for an urgent appointment they would be seen on the day and telephone consultations where offered either with a nurse or GP.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online 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

Are services responsive to people's needs?

(for example, to feedback?)

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.

Longer appointments were also available for older patients, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits would be made to the local care home if appropriate following a telephone consultation with a GP.

The January 2015 national patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 77.8% were satisfied with the practice's opening hours compared to the CCG average of 77.4% and national average of 75.7%.
- 62% described their experience of making an appointment as good compared to the CCG average of 68.8% and national average of 73.8%.
- 60.9% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61.7% and national average of 65.2%.
- 77.9% said they could get through easily to the surgery by phone compared to the CCG average of 68.9% and national average of 74.4%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Patients we spoke with said that they do not always see the same doctor each time and that at times it is difficult to get through on the telephone. Routine appointments were

available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place 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 in both surgery waiting areas to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever made a complaint about the practice.

We looked at 14 complaints received in the last 12 months and found that they were handled appropriately. Response letters to patients included a thank you for informing the practice of the complaint. The practice also recorded verbal complaints and communicated these to all staff via notifications sent through the electronic computer system. Patients had also left comments on the NHS choices web site. All comments had been acknowledged by the practice. If there were any negative comments the practice manager would ring the patient if the contact details were left. Alternatively they would post a reply to ask the patient to contact the practice manager to discuss further. An apology was always given and thanks were given for the positive comments.

The practice reviewed complaints to detect themes or trends and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. The practice stated that their vision and values were to provide appropriate and accessible primary healthcare services to meet the individual and cultural healthcare needs of their practice population.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive on any computer within the practice. We looked at 10 of these policies and procedures and most had a cover sheet that showed they had been reviewed annually. Others did not have a date or where due for review in 2014 and therefore it was not clear if they were up to date and correct.

Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example fire risk assessment and action plans for both buildings were seen.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and two GP's were the leads for adult and children safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards in most areas. We saw that QOF data was regularly discussed at clinical meetings.

The practice regularly submitted governance and performance data to the CCG.

The practice held protected learning sets every six months when governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. Full practice meetings where all staff were able to attend other than these were not in place.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example, employment pack, HR policy, prevent illegal working policy and equal opportunities policy) which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy and staff we spoke with were aware of this and knew what to do however staff did not know where the policy was. The whistleblowing policy was part of the safeguarding policy rather than a separate policy which meant staff were unable to locate it.

Leadership, openness and transparency

The partners in the practice were available when required in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every six months. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. They felt confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups. For example, older people, people with long term conditions, the working age and those recently retired. The group consisted of a mix of English, British white, Indian and Hindu patients from across both sites. The PPG had carried out surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which

Are services well-led?

Good 

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

was considered in conjunction with the PPG. The results, actions agreed from these surveys and minutes were available on the practice website. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

We also saw evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also 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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at nine 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 and that they had staff away days where guest speakers and trainers attended.