Dr Feisal Docrat

Quality Report

St Peter's Health Centre
Sparkenhoe Street
Leicester
LE2 0TA
Tel: 0116 2957835
Website: www.shefamedicalpractice.co.uk

Date of inspection visit: 7 July 2014
Date of publication: 24/10/2014

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.

Contents

Summary of findings

Overall summary

The practice provided GP services to over 4000 patients in the centre of Leicester. The practice is based at St Peter's Health Centre, Sparkenhoe Street, Leicester. The premises is a new building owned by Leicestershire Partnership NHS Trust (LPT). The practice provides a range of primary medical services including: health promotion and disease management, minor surgery, child immunisation and a baby clinic.

This was an announced inspection, which focused on whether the care and treatment of patients was: safe, effective, caring, responsive and well led. We spoke with six patients during our inspection. We also received 12 comment cards, and reviewed written and verbal feedback from patients and observed how staff interacted with patients. Most of the feedback about patients' care and treatment was positive.

The practice had conducted a patient survey, and the results were available on the practice's website. The results for 2013/14 showed that 98 patients had taken part in the survey. Comments were generally very positive. Also on the website was an action plan which had been produced as a result of the comments in the 2013/14 survey. The action plan addressed a number of issues and included time scales for action.

As part of the inspection we reviewed Information from Leicester City Clinical Commission Group (CCG) and Public Health England.

We found the practice understood the needs of its patient population and provided flexible and responsive services to meet their needs. Patients told us they sometimes had difficulty accessing the service through the telephone system.

Staff said they were well supported by the GPs and practice manager and that they found them open and approachable. We saw that there were systems in place to safeguard children and vulnerable adults from abuse, and staff were aware of the procedures to follow to achieve this.

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

We found that the practice was not following National Institute and Care Excellence (NICE) guidelines in respect of clinical audits. As a result we have set a compliance action as this is a breach of the regulations.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Shefa Medical Practice was safe.

We saw that accidents and critical incidents had been recorded. A review of the information showed that there had been a small number of both. However, we did not see that any analysis of either had taken place; therefore the practice was unable to demonstrate it had learnt from the incidents.

There was a lead GP for safeguarding incidents and investigations involving both children and vulnerable adults. We saw that there had been no recent safeguarding issues related to either children or adults.

The practice was not a dispensing practice and as a result there were very few medicines at the practice. The medicines that were there were stored securely and were within their 'best before' date. We found that the practice had consistently lower rates for antibiotic prescribing when compared to other practices in the local area. High rates of antibiotic prescribing have been identified as a problem within the National Health Service (NHS). The practice also uses vaccines at their inoculation clinics. The vaccines were stored securely and at an appropriate temperature.

The premises were visibly clean, and the necessary checks on the water systems for Legionella required by Health and Safety Executive (HSE) had been carried out.

Staff had been recruited in a safe and consistent manner. All of the necessary checks on each staff member's competence and background had been completed as required by the Health & Social Care Act (2008)

The practice had a fire risk assessment in place. However, necessary checks that should have been recorded in the fire log book had not always taken place. The practice had a business continuity plan which identified what action to take in an emergency situation, such as a power failure. Staff working at the practice were aware of what to do, and the location of the plan for reference.

The equipment being used at the practice had been checked and where necessary calibrated to ensure that it was working properly

Are services effective?

Shefa Medical Practice was not effective and improvements were required.

Summary of findings

The practice had patients from many diverse cultures, nationalities and backgrounds. As a result many different languages were spoken by the patients at the practice. Staff at the practice spoke English, but many also spoke a second or third language, particularly the languages of south Asia. In addition the practice had access to an interpreting service and language line, which is a telephone interpreting service. However, the information leaflets in the waiting area were mainly written in English. We found that information was available in other languages, however this was in relation to specific illnesses or conditions, and the patient usually had to ask for it.

The practice had targeted diabetes management within the practice. Information received from the Clinical Commissioning Group (CCG) identified that there was a higher rate of diabetes in the practices' local area. Particularly among people originating in south Asia.

The practice was not working within the National Institute for Health and Care Excellence (NICE) guidelines for clinical audit. While we were told that clinical audit was taking place, there were only limited records to demonstrate this in practice.

Staff were given time by the practice to attend training. This was a city wide initiative for GP practices and took place one afternoon every month, focussing on clinical skills.

Staff training records at the practice identified that most staff were up to date with essential training.

The practice received information from the out-of-hours service when they had seen any patients registered at the practice. Information received from the out-of-hours service was checked and recorded within 24 hours of its receipt.

The practice had a lead GP for end of life and palliative care. Patients entering this stage of their life had specific care plans and were supported and monitored by the GP lead. The practice had been using the 'Better Care Fund' which was a Government initiative from the Department of Health (DoH) and the Department for Communities and local Government. The Better Care Fund aimed to improve dignity, independence, and reduce hospital admissions. This was being particularly targeted at elderly and vulnerable patients at the practice.

Are services caring?

Shefa Medical practice was caring.

Summary of findings

Patients were treated with dignity, respect and consideration. The reception staff were polite, courteous and welcoming. Comments received on comment cards said the receptionists were very polite and kind, and there were very helpful trained staff.

Patients spoke positively about the staff being caring, and not feeling rushed. Staff were approachable and friendly. The practice had a hearing induction loop to assist patients who used a hearing aid. Hearing induction loops are required 'where reasonably possible' by the Equality Act (2010).

Patient records were stored securely and there were systems and practices in place to protect the confidentiality of information. Patients said they did not have any concerns regarding confidentiality at the practice.

The practice had a lead GP for bereavement. The GP said that they took this responsibility seriously and bereaved families were offered support. Within Leicester there are specific support services for the bereaved, and the practice assisted families in accessing their services and support.

Are services responsive to people's needs?

Shefa Medical practice was responsive.

Health checks and medication reviews were available and offered to patients whose circumstances warranted them having either a health check or a medication review.

The practice had an active Patient Participation Group (PPG.) 'The PPG provides a link between the practice to better understand its patients and encourage better healthcare through communication.' (From the Shefa Medical practice website.) Unfortunately we were not able to meet with the PPG during our inspection. However, we did see that information relating to patient surveys, action plans and minutes of meetings was available on the practice's website.

St Peter's Health Centre had level access for patients with restricted mobility or who were in a wheelchair. There was an assisted toilet available for patients who had a physical disability, and therefore required additional room or support.

The practice offered patients the opportunity to book routine appointments on-line through the practice's website. There was a simple registration process to go through, and then once registered patients could book routine appointments and order repeat prescriptions.

Patients at Shefa Medical Practice had access to choose and book. Choose and book is a national electronic referral service. The service

gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. As a result patients had control over their referrals, rather than being seen at a hospital or clinic they would not choose.

We saw that the practice offered home visits to their patients based on need, and usually as a result of the patient being physically unable to attend the surgery.

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice.

Are services well-led?

Shefa Medical practice was well-led.

Senior managers at the practice were open and approachable. Clinical staff were well supported. The reception staff gave a clear sense that the patients were at the heart of the practice's approach. Staff attitudes were positive and we saw that reception staff wanted to deliver a good service and good customer care.

The practice had a range of policies and procedures in place covering all aspects of the practice's clinical and administrative operation. There were identified members of staff to take the lead in areas such as bereavement and safeguarding. There were clear lines of responsibility within the practice, and a structure through the staff team.

We identified that practice issues were discussed both formally and informally. It was clear that the emphasis was often on informally. As a result we saw that minutes of meetings either did not reflect the issues discussed, or the meetings had not been formally minuted. As a result it was difficult to track progress, or to identify who was responsible for any actions discussed and identified.

The practice provided the opportunity for personal and professional development for staff by participation in a range of training appropriate to their role. This included areas such as chaperone training, clinical skills training, and also training in areas such as fire safety and safeguarding vulnerable adults and children.

The practice had a patient participation group (PPG) which worked to support the practice. We saw that information about the PPG was displayed in the surgery and also on the practice website.

Summary of findings

We found that significant events were discussed at staff meetings. However, the records did not always reflect the full discussion, and it was not clear that learning from significant events had taken place.

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

In line with guidance from the British Medical Association (BMA) every patient over the age of 75 had a named GP. Older patients sometimes presented as being vulnerable, and the reception staff said they were aware of this. Older patients were offered the opportunity to have an appointment with a chaperone.

Within the waiting area there were leaflets relating to memory issues, and links with support services for older people. Staff said that there were links with local care homes for elderly people. Discussions with both staff and patients who fell into this group identified that both thought their needs were identified and met by the practice.

The practice told us that they offer an appointment the same day, or a home visit where applicable.

People with long-term conditions

The practice operated a number of clinics for patients with long term conditions, such as patients with diabetes, leg ulcers and chronic obstructive pulmonary disease (COPD). Patients were kept under review, and there were systems for making referrals to other care agencies when required. Some patients with long-term conditions were receiving medication. The practice reviewed medication for these patients routinely every six months. Administrative staff at the practice were able to demonstrate how letters were routinely generated to invite patients for medication reviews. In addition they were able to show how patients were called and recalled to be seen about their condition. Administrative staff also demonstrated how any patients who did not attend for their follow up appointment were contacted by telephone to arrange a suitable appointment.

The practice said that they offer patients with long-term conditions an annual review with the Practice Nurse. In addition patients have a blood test every six to twelve months depending on their condition. Patients with long-term conditions tend to be taking medication, and often a combination of medicines. The practice offered a medication review, with a face to face consultation so the patient has the opportunity to talk about the medicines they have been taking.

Summary of findings

Mothers, babies, children and young people

A specific GP at the practice tended to see those patients who were mothers, babies, children or young people. This allowed for continuity of care for patients who said they knew who they were seeing. The practice had a midwife working at the surgery every Tuesday. The practice also ran a vaccination clinic every Wednesday. The GP also handled advice about contraception, and this included access to the emergency morning after pill. Both patients and staff at the practice said they felt the needs of this patient group were catered for and met.

The practice said they offered postnatal services for new mothers, antenatal services for women during their pregnancies.

The working-age population and those recently retired

To meet the needs of patients within this population group the practice opened late three times a week. Monday, Wednesday and Thursday until 8.00 pm. Patients aged 40 years and over were offered annual health checks. We saw that there was information available in the waiting area that would particularly relate to patients in this age group. For example smoking cessation and weight loss.

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

The practice had a lead GP for vulnerable groups of patients seen within the surgery. This included patients who had a learning disability, and people with mental health needs. Patients who were homeless or who were travellers had their health needs met at the Dawn Centre which operated a specialist service specifically for homeless people. The Dawn Centre was situated a few hundred yards away from the practice. Staff at the practice signposted patients from these vulnerable groups to the Dawn Centre. If a patient presented who was not registered at the practice looking for the morning after pill, they would be directed to family planning clinic on the 2nd floor. In addition sex workers were offered the morning after pill, and referred on to the health centre.

The practice said they had few patients with learning disabilities. These patients were known to the staff who said that communication was key to meeting their needs. In many cases the GP operated as a gateway for referral to more appropriate or specialist services. Patients who had a learning disability had a health review annually; in addition patients with a learning disability could see a GP on the same day they made their appointment. Patients with a learning disability also had their medication reviewed every six months.

Summary of findings

The practice said that there was the possibility for patients to register as a temporary patient if they are in Leicester for a short stay.

People experiencing poor mental health

Shefa Medical Practice does have some patients who have mental health needs. Reception staff said they try to treat all patients with respect. Staff also said that sometimes patients with mental health needs arrive at the practice without an appointment. In these circumstances the reception staff would seek advice from a GP. Discussions with GPs at the practice identified that there were good networks between the practice and mental health services within the city. If a referral to another care provider or support agency was indicated this would be made.

Staff also told us that there were good links with the Maidstone Centre, which is where the Community Mental Health Team is based.

The practice said that there was a drive towards non-discrimination, with patients who had mental health issues treated equably. Annual blood tests were offered to all patients with mental health issues. GPs were aware of the changing nature of mental health, and medication is frequently reviewed.

Summary of findings

What people who use the service say

Prior to our inspection we left comment cards for patients to complete and leave in a secure box in the waiting area and submit. We received twelve completed comment cards. Eleven were positive with three being extremely positive. The one negative comment related to the appointments system.

The practice had conducted a patient survey, and the results were available on the practice's website. The results for 2013/14 showed that 98 patients had taken part in the survey. Comments were generally very positive. Also on the website was an action plan which had been produced as a result of the comments in the 2013/14 survey. The action plan addressed a number of issues and included time scales for action.

We had an Expert by Experience as part of our inspection team. An Expert by Experience is a person who has had experience of using this type of service and helped us to capture the views and experiences of patients. Our Expert by Experience spoke with six patients in the waiting area during the morning of our inspection. The Expert by Experience spoke with patients from different ages and population groups to get a feel for how the practice met the needs of a range of different patients.

We received positive feedback from a patient attending the practice for a specific clinic. They thought the practice offered a very good service and they had a good rapport with the staff, who were friendly and approachable. They had been asked to provide feedback, and had been happy to do so. Their feedback had been positive. The only 'grumble' was that the practice was not open at weekends. A second patient attending a different clinic was also happy with the care and treatment they were receiving. They particularly thought that they were treated with respect by all of the staff.

Another patient we spoke with also provided positive feedback. They thought the GP practice provided an excellent service. This patient had walked in without an appointment and had been fortunate to be seen as the practice was not busy. They said all of their family was registered at the practice and they were very happy with the way the whole family had been treated. Another patient however, had not found making an appointment easy and had turned up without an appointment and had to wait some considerable time.

Another patient we spoke with said they rarely came to the doctors, however, when they did, they usually saw the same GP which was good from the point of view of continuity. This patient rated the practice as 8/10, when asked why not 10/10 they said because it was not easy to get an appointment. They said they thought the staff were all very good, and the reception staff were polite and respectful.

The final patient we spoke with had children with them. The patient said they liked the doctor and thought that he always treated their family well. They said they had rung that morning and they were surprised to get offered an appointment straight away. They said that it's not always easy getting an appointment. We asked whether they felt rushed during their appointment, and they said never. The doctor always takes the time needed to see me properly.

Discussions with all of the patients about other services showed that they were aware. One patient said they had seen signs for the mental health team, and all of the patients were aware of the leaflets in the waiting area. Although one patient said they seem to be quite scarce, and another patient pointed out that they were written in English.

Areas for improvement

Action the service MUST take to improve

The practice must follow National Institute for Health and Care Excellence (NICE) guidelines in respect of clinical audits. These audits must be documented and it there must be an audit trail to show that learning has taken place following the audits.

Action the service SHOULD take to improve

The practice should analyse the accidents, complaints and critical incidents that have occurred, discussthem in staff meetings and keep a record. This would enable the practice as a whole can learn from what has happened and make improvements in the future.

Summary of findings

The information leaflets in the waiting area could and should be available in a variety of different languages. This is particularly important as many of the practice's patients do not speak English as their first language.

Minutes of meetings within the practice either did not reflect the issues discussed, or the meetings were not formally minuted. As a result it was difficult to track progress, or to identify who was responsible for any actions discussed and identified. The practice should ensure that minutes are taken of all meetings, and any action is identified along with the person responsible.

The practice should have an internal performance review for the practice as a whole, and the results should be recorded to enable staff to focus on improvements.

Dr Feisal Docrat

Detailed findings

Our inspection team

Our inspection team was led by:

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

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

Background to Dr Feisal Docrat

Shefa Medical Practice is a GP practice which provides a range of primary medical services to over 4,000 patients from a practice in the centre of the City of Leicester. Their services are commissioned by Leicester City Clinical Commissioning Group (CCG). The service is provided by one GP, an associate GP, and a long-term locum GP. In addition there is a Nurse Practitioner; The GPs and nurse are supported by a practice manager, reception and administration staff. Local community health teams support the GPs in provision of maternity and health visitor services.

The practice has one location registered with the Care Quality Commission (CQC). This is at St Peter's Health Centre, Sparkenhoe Street, Leicester. LE2 0TA. Shefa Medical Practice is registered to provide the following regulated activities at that location: diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder and injury. This is the first inspection of the regulated activities carried out at this practice.

The practice is in a new building. Parking is available in surrounding streets and there is limited car parking space at the practice. This includes car parking space designated for use by people with a disability.

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

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Detailed findings

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received twelve completed cards. We carried out an announced visit on 7 July 2014. During our inspection we spoke with a range of staff including clinical and non-clinical staff and spoke with patients who used the service and family members. We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

We received information about the PPG and the ways in which they support the practice.

Are services safe?

Our findings

Safe patient care

The Health and Social Care Act (2008) identifies a number of incidents and circumstances that must be notified to the Care Quality Commission (CQC). To date CQC have not received any notifications from Shefa Medical Practice. Discussions with the practice manager identified that none of the notifiable incidents or circumstances had occurred at the practice.

The Health & Safety Executive (HSE) define a critical or major incident as: 'A significant event, which demands a response beyond the routine, resulting from uncontrolled developments in the course of the operation of any establishment or work activity.' We discussed critical incidents with both a GP and the practice manager. Both said that there had been very few incidents which fell into the scope of critical incidents. However there had been some incidents, and we found that these had not always been recorded or analysed in a manner which would allow the practice to learn from the incidents.

We talked with a GP and discussed patients who had experienced multiple falls, and how they were treated. The GP explained that there was a clear pathway for referral to the falls and balance clinic. We saw the documentation for making the referral. We did not however, see any audits of the number of patients who had experienced falls, or any analysis to identify whether there were any trends or action points for the practice.

The practice had an accident book to record any accidents that occurred to staff or patients. On reviewing the information we saw that there were no entries recorded during 2014. There was information available relating to Reporting of Injuries, Diseases, and Dangerous Occurrences (RIDDOR). This is a statutory obligation to report deaths, injuries, diseases, and dangerous occurrences including 'near misses' that take place at work or in connection with work. The documentation showed that no RIDDOR reports had been made by the practice during 2014.

The GP said that there had been no incidence of healthcare acquired infections (HCAI's). Staff had been screened for methicillin-resistant staphylococcus aureus (MRSA) by way of a nasal swab during the period 2013 to 2014.

Discussions with patients at the practice identified that they had no concerns regarding safety.

Learning from incidents

The practice has a system in place for reporting, recording and monitoring significant events. The practice manager showed us the significant events file which had been in operation since June 2013. We noted that from June to December 2013 there were three significant events recorded. A further four had been recorded during the first half of 2014. The practice manager said that significant events were discussed in practice meetings. However, on reviewing the minutes of practice meetings we saw that a record of the discussions did not always appear in the minutes. Of the seven significant events recorded only one related to a clinical issue. The practice manager said this was discussed in a meeting between the GPs. The practice manager was not able to show us any documentation related to that meeting, or evidence that the issue had been discussed and resolved. One of the issues related to scanning of documents. We asked for a copy of the policy and procedure for scanning documents. A copy could not be located in the policy and procedure file or on the computer. We were given a copy later in the inspection. The failure of the practice to promptly locate an important policy suggested that staff might not have access to guidance to help them in the safe execution of their duties.

The practice manager said that there were no formal lessons learnt meetings held at the practice. However, informal discussions did take place, although there were no minutes or evidence of what was discussed. The practice manager agreed that formal meetings with minutes would be useful.

We reviewed the practice's computer system, which is where all of the policies and procedures were stored. The files on the computer had not been audited and there were many policies which had either been updated or were no longer relevant. This was confusing, and the practice could not be sure that staff would view the latest version of a policy, as there were several to choose from. Discussions with several staff revealed they could access the computer if they were looking for a policy or further information.

Safeguarding

One of the GPs was the safeguarding lead for both vulnerable adults and children. We were told by the lead GP for safeguarding that there had been no recent safeguarding issues.

The staff members we spoke with said they had completed safeguarding training and were aware of safeguarding

Are services safe?

responsibilities for both children and adults, and could describe what to look for and what action to take. Staff training records supported that safeguarding training had been completed by the staff.

We reviewed the practice's chaperone policy. A chaperone would be a health care professional who was present while a GP or nurse carried out an examination or treatment. Particularly if that examination or treatment was of an intimate nature. The chaperone's role was to protect the patient and the GP or nurse from inappropriate care, or accusations of improper actions. During our inspection we spoke with two members of staff who said they had been trained as chaperones. Both gave examples of when they had acted in this role. The chaperones said they completed a written document recording their chaperone experience afterwards and this was scanned and attached to the patient's notes.

Monitoring safety and responding to risk

We found that the systems to identify, assess and manage risks relating to the health, welfare and safety of patients and others were inadequate. We discussed health and safety risk assessments with the practice manager who said that these were completed annually. However the documentation lacked detail, and depth, and had no obvious analysis of the risk. We saw a basic fire safety risk assessment, but again this lacked detail and was insufficient for its purpose.

We have passed on our concerns related to fire safety to Leicestershire Fire and Rescue Service.

The practice told us that there were some 'looked after children' (those in the care of the state, usually through the local authority, including children who are subject to a care order and those receiving a short break or respite care) registered with the practice. However, the GP said that the practice did not routinely monitor those children, and responsibility for this was with the Health Visitors. We were told that there were no planned multi-agency meetings about these children, and any meetings were on a basis of need.

Medicines management

Shefa Medical Practice is not a dispensing practice; therefore patients used local pharmacies to get their prescription medication dispensed. We inspected the emergency medicines held at the practice and found that all of the medicines were in date and stored securely.

Vaccines were stored in a refrigerator, and we saw that the temperature was monitored and recorded. A random selection of vaccines were checked and found to be in date. We therefore were able to judge that medicines at the practice were managed safely and in accordance with guidance and policies.

The GP told us that the practice had consistently lower rates for antibiotic prescribing when compared to other practices in the local area. High rates of antibiotic prescribing have been identified as a problem within the National Health Service (NHS).

Cleanliness and infection control

Patients we spoke with during our inspection told us they felt the practice was clean. We saw that clinical and communal areas including the toilets appeared visibly clean. Staff said that there was a cleaning contract in place with an external company

Shefa Medical Practice were tenants in St Peter's Health Centre. Responsibility for legionella testing was with the building landlord. We were shown evidence that the landlord had taken the necessary steps with regard to legionella testing. There are legal regulations in place in the UK that cover the area of legionella control and water systems, and they are enforced by the Health and Safety Executive (HSE). Any organisation with public access to their water system has a duty of care to ensure there is a risk assessment in place to ensure legionella does not become a danger to health.

Staffing and recruitment

During our inspection we checked staff personnel files, and saw that every member of staff had a personnel file. The files contained all of the information required by the Health and Social Care Act (2008) Regulations that would show that the person had been recruited in a safe and thorough manner. This included: a photograph, application form or curriculum vitae (CV), work history, proof of identity and where appropriate a Disclosure and barring scheme check (criminal records check).

Discussions with both staff and patients did not highlight any concerns over staffing levels at the practice. However, we were made aware that on occasions the GPs are very busy. The locum GP had helped to relieve the pressure;

Are services safe?

however, the very nature of locum staff is that they are temporary. The provider said that he was considering this situation, and discussions were on-going with regard to the number of permanent GPs at the practice.

Dealing with Emergencies

Discussions with staff working in reception identified that there was an emergency panic button for staff to summon assistance if needed. This was part of the computer system, and also had links to alert the police if necessary. Staff were aware of what action to take should the panic button be activated, although no staff member could recall it ever having been activated.

We discussed adverse weather and what steps the practice would take to ensure that there was continuity at the practice. The practice manager said that many of the staff lived locally, and would be able to walk to work. We saw the business continuity plan which identified what steps should be taken in the event of a major emergency. This would be particularly in relation to an event that affected how the practice ran, such as a flood, power cut or adverse weather. The plan had been reviewed, and covered the areas that a business continuity plan would be expected to cover.

We saw that the practice had a fire log book and a fire risk assessment. The fire log book contained details of the regular checks and tests that should have been carried out in relation to fire safety. An inspection by the building landlord in April 2013 identified that: 'Log book checks have not been carried out for some time.' Since that inspection fire safety checks had improved, although we saw that there were still some gaps in the records. As a result the provider was not able to demonstrate that patients and staff were protected against the risks associated with fire safety. We passed on our concerns to Leicester Fire & Rescue service.

Equipment

During our inspection we saw a range of different equipment including a medical refrigerator, a defibrillator and a spirometer. A defibrillator is a machine for providing electric shocks to re-start the heart in an emergency. A spirometer is an apparatus for measuring the volume of air inspired and expired by the lungs. The practice manager showed us documentation relating to weekly checks of the equipment, and we also saw maintenance agreements where they were required.

The practice had a specific file for recording information relating to equipment. The file included a description, the serial number for identification where present, any details related to the calibration of the equipment and dates of tests and re-tests. Staff were able to show this file to the inspection team, and demonstrate that they had confidence that all of the equipment was working correctly and had been routinely checked.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

We discussed patient care with the nurse practitioner. There were two healthcare assistants allocated to work during the morning of our inspection visit. One carried out NHS health checks including respiratory checks. The reception desk acted as a triage point, and calls were put through to the nurse practitioner if the reception staff were unsure. The nurse practitioner said that the practice was doing very well with regard to diabetes management. Information received from the Clinical Commissioning Group (CCG) identified that there was a higher rate of diabetes in the population group served by the practice, particularly among people with their origins in south Asia. The nurse practitioner however, said that the practice worked with patients around lifestyle choices. Many patients had a poor diet, or lacked of exercise and this contributed to their diabetes problems. This had led to patients receiving targeted advice, and support, to tackle specific health problems among this patient group. The nurse practitioner said that this had produced positive results.

The practice had a consent policy in place which provided guidance to staff when they gave care and treatment to patients. The consent policy made reference to the Gillick competency for assessing whether children under 16 were mature enough to make decisions without parental consent. This allowed professionals to demonstrate that they had checked a person's understanding of proposed treatment, and used a recognised tool to record the decision making process. The GP told us that they did not currently have any specific examples where they had needed to apply the Gillick competency. We were also told that patients tended to go to either a female GP or the practice nurse (also female) for issues related to Gillick competency.

The staff training records showed that staff had received training in the Mental Capacity Act (2005) (MCA) and 'best interest decisions'. Discussions with several staff members showed that they were aware of best interest decisions. Staff also were able to demonstrate an understanding between the MCA and vulnerable patients that might be seen in the practice.

With regard to specific blood results these were not shared with a patient until they had been reviewed by a GP. In most cases blood test results were given out over the telephone. However, if the patient required an appointment this would be arranged so that the GP could discuss the test results in person.

Management, monitoring and improving outcomes for people

The practice did not have a formal system in place for completing clinical audit. We were told by the GP provider that systems were informal with meetings being held during a coffee break or in between seeing patients. There were no minutes and it was not possible to evidence that clinical audits had taken place. This was not in keeping with National Institute for Health and Care Excellence (NICE) guidelines. Discussions with clinical staff did not raise any concerns with regard to knowledge or competency, however there was a clear lack of documentary evidence to support that view. As a result the practice was unable to demonstrate that they regularly assessed and monitored the quality of service.

In preparation for our inspection of Shefa Medical Practice we examined the QOF database. The Quality and outcomes framework (QOF) is a system of payment to general practices for providing good quality care to their patients. It also helps fund work to improve the quality of health care delivery. QOF is a fundamental part of the General Medical Services (GMS) contract introduced on 1 April 2004. Most if not all GP practices in the country submit QOF data to NHS England, where it is analysed and compared both locally and nationally. There are a number of QOF indicators such as: coronary heart disease, cancer, mental health, obesity, smoking and diabetes. The QOF data compared favourably against national and local statistics in all areas apart from asthma, obesity, diabetes and depression. We discussed these areas with clinical staff at the practice and saw that patients within these groups had been particularly targeted to help improve patient's health.

Staffing

We checked the staff personnel files for eight members of staff. We saw that where the staff member had a professional qualification this had been checked, and the revalidation (checking it was up to date and current) had been completed.

We reviewed the staff training records at the practice. We saw that most staff were up to date with essential training. We also saw that there was a training plan to ensure that all staff received the required training. This included training in

Are services effective?

(for example, treatment is effective)

fire safety, resuscitation which included use of the defibrillator, and safeguarding vulnerable adults and children training. We talked with several members of staff about training. Staff members were able to answer questions and discuss examples which identified they had received the training and could put their learning into practice.

The practice manager demonstrated the web mentor system, which was available for on-line guidance. This was part of Leicester's hospital intranet, and was a computer based system that gave support, advice and training to staff working across the National Health Service (NHS) including GP practices. The practice manager explained how staff at the practice received training and support as well as information and guidelines from the Leicester Medicines Strategy Group (LMSG) which they accessed through the intranet.

Working with other services

We discussed how Shefa Medical Practice worked with other services with both the GP and the practice manager. Both said there were well established systems for making referrals to other agencies. The practice manager showed us the contact details for clinics and hospital services, and explained how a patient would be referred to access these services. The GP talked about specific referrals to different services, and demonstrated how this was achieved.

The practice received information from the out-of-hours service when they had seen any patients registered at the practice. Both the practice and the out-of-hours service used System One which is a computer system used to share patient information. The GP said that information received from the out-of-hours service would be checked and recorded within 24 hours of its receipt.

Health, promotion and prevention

We saw the pre-registration pack given to new patients. This contained a questionnaire about lifestyle, alcohol, exercise and weight issues. After completion of the questionnaire new patients were offered a consultation with a GP to discuss their health needs and status.

The practice had a lead GP for end of life and palliative care. Patients entering this stage of their life had specific care plans and were supported and monitored by the GP lead. The practice had been using the 'Better care fund' which was a Government initiative from the Department of Health (DoH) and the Department for Communities and local Government. The Better care fund aimed to improve dignity, independence, and reduce hospital admissions. This was being particularly targeted at elderly and vulnerable patients at the practice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Our observations of the staff were that patients were being treated with dignity, respect and consideration. We saw that reception staff were polite, courteous and welcoming. Comments received on the comment cards talked of receptionists being very polite and kind, and identified that there were very helpful trained staff. We also received comments saying the staff were very caring, friendly and helpful.

The patients we spoke with also talked positively about the staff being caring, and not feeling rushed. Several patients said that the staff were approachable and friendly. The practice had a hearing induction loop to assist patients who used a hearing aid. Hearing induction loops are required 'where reasonably possible' by the Equality Act (2010).

Throughout our inspection we found staff to be committed and caring. Discussions showed that staff felt part of a team and were focussed on the needs of the patients.

We discussed confidentiality with a number of staff. Patient records were stored securely and there were systems and practices in place to protect the confidentiality of information. Several staff members commented on the fact that the reception desk was not very private. We also observed that the reception desk was close to the waiting area, and it could be possible to overhear conversations at the desk. However, we did not see any examples of this, and patients said they had no concerns about their confidentiality at the reception desk. Reception staff were aware of the need for confidentiality and said that a private room was available if required to discuss anything with any particular patient.

The practice had a lead GP for bereavement. The GP said that they took this responsibility seriously and bereaved families were offered support. Within Leicester there are specific support services for the bereaved, and the practice assisted families in accessing their services and support.

Involvement in decisions and consent

We spoke with six patients in the waiting room. All six said they did not have any issues with regard to consent. They said that they were happy that their care and treatment was explained to them, and they were given the opportunity to ask questions and express their views.

We discussed consent with the nurse practitioner who showed us several information leaflets about different conditions and illnesses. The nurse said that the leaflets were useful when explaining to patients information about their condition or illness. Patients were able to make informed consent decisions about their care, as they had access to the information.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw that Shefa Medical Practice worked well to meet and respond to the needs of patients in each of the population groups we considered. Health checks and medication reviews were available and offered to patients whose circumstances warranted them having either a health check or a medication review. The GP provider said that these usually occurred every six to twelve months, and the patient would be asked to make an appointment. The patient's notes alerted the GP when this was due.

Discussions with both staff and patients identified that due to the ethnic diversity of the area in which the practice was located, patients spoke many different languages. We saw that often a patient would choose a GP because they could speak the same language. Across the whole staff team we saw that many different languages were spoken, particularly languages from south Asia. The practice manager said that an interpreting service was available, although this was difficult to arrange, particularly at short notice. The practice had used language line (a telephone interpreting service) in the past particularly for patients who came from eastern Europe.

Access to the service

St Peter's Health Centre had level access for patients with restricted mobility or who were in a wheelchair. There was an assisted toilet available for patients who had a physical disability, and therefore required additional room or support.

Patient's views with regard to accessing the practice through the appointments system varied. Some patients said it was very difficult, and had expressed their frustration by making formal complaints. Patients who said they had made a formal complaint, also said that their complaint had made not always had the desired effect. Others said that it could be difficult but usually they got an appointment with the GP they wanted to see at a convenient time.

The practice offered patients the opportunity to book routine appointments on-line through the practice's website. The practice manager explained there was a simple registration process to go through, and then once registered patients could book routine appointments and order repeat prescriptions.

We discussed waiting times with patients. They said that once they had arrived at the surgery generally waiting times were not too bad. Patients said the GPs and nurses tended to be pretty good at keeping to time. In addition the practice offered late opening times until 8:00 pm three days a week.

Patients at Shefa Medical Practice were able to access choose and book. Choose and book is a national electronic referral service. The service gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. As a result patients had control over their referrals, rather than being seen at a hospital or clinic they would not choose.

The practice offered home visits to their patients based on need. Usually this was for older patients.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We discussed making complaints with reception staff. We saw that there were leaflets and a poster available for patients about how to complain. The leaflets and the poster in the waiting room were only written in English. However, many of the patients at the practice were from overseas and English was not their first language. Reception staff said that the practice did receive complaints, and these were mainly about the appointment system and the lack of car parking. Reception staff said that confidentiality was difficult at the desk due to the open plan nature of the waiting room. Therefore any patients wanting to complain were usually seen in a private room.

We discussed complaints with the practice manager. We were shown the complaints file, and this contained information relating to a number of complaints received in the previous year. On reviewing the file we found that information relating to the outcome in some cases was missing, and could not be located. The practice manager assured us that the outcome had been concluded, and recorded.

The practice manager explained that any complaints received would be discussed in the practice meetings. We saw the minutes of one practice meeting which made reference to a complaint that had been received.

Are services well-led?

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

Our findings

Leadership and culture

The practice had a statement of purpose setting out their aims and objectives. We spoke with several members of staff who said they felt there was a good team approach. Staff said they felt well supported and they felt they were listened to. Several staff members said they thought the senior managers at the practice were open and approachable. Clinical staff said they felt well supported and respected in their role. When speaking with staff there was a clear sense that the patients were at the heart of the practice's approach. Staff attitudes were positive and we saw that reception staff wanted to deliver a good service and good customer care.

Governance arrangements

We saw that the practice had a range of policies and procedures in place covering all aspects of the practice's clinical and administrative operation. There were identified members of staff to take the lead in areas such as bereavement and safeguarding. We also saw that there were clear lines of responsibility within the practice, and a structure through the staff team. Discussions with members of staff identified that they felt able to seek guidance from other colleagues, and able to gain support from them.

Discussions with both the practice manager and the provider GP identified that practice issues were discussed formally and informally. It became clear that the emphasis was often on informally. As a result we saw that minutes of meetings either did not reflect the issues discussed, or the meetings had not been formally minuted. This meant that it was difficult to track progress, or to identify who was responsible for any actions discussed and identified.

Staff at the practice had the opportunity for personal and professional development by participation in a range of training appropriate to their role. This included areas such as chaperone training, clinical skills training, and also the mandatory training in areas such as fire safety and safeguarding vulnerable adults and children.

Systems to monitor and improve quality and improvement

Leicester City Clinical Commissioning Group (CCG) carried out an annual quality review (AQR) of all GP practices with whom it commissioned services. We saw that the practice had undergone an AQR, and had produced a plan to achieve improvement.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG). We saw that information relating to patient surveys, action plans and minutes of meetings was available on the practice's website. Reviewing the PPG's action plan, we could see that they were actively looking to improve the patient's experience. This was in areas such as improving confidentiality at the reception desk and addressing the number of patients who did not arrive for their appointments.

Staff engagement and involvement

We received information about the PPG and the ways in which they supported the practice. This included seeing minutes of PPG meetings and discussing the group's involvement in the patient survey with the practice manager. Members of staff who we spoke with viewed the PPG as making a positive contribution to the practice. Minutes of meetings and the key objectives for the group were available on the practices' website.

Learning and improvement

We asked the practice manager and the provider GP to see the in-house performance review for the practice as a whole, or the NHS England equivalent. This was a document that identified the strengths and weaknesses of the practice. It would also identify areas for improvement, and draw conclusions about how well the practice was meeting the needs of its patients. Both the practice manager and the GP provider said that while they had undertaken performance reviews, these had not been recorded.

Staff were given time by the practice to attend training every month. The practice closed for the afternoon to enable all staff to attend this training. During this time the out-of-hours service covered the practice to meet patient needs. Patients were informed about the staff training and practice closure in advance.

We also saw that staff were able to access further training through the Leicester training directory. This was arranged

Are services well-led?

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

through Leicester City Council. Staff would submit their application via the practice manager who would discuss the application with the provider GP where training was agreed. Staff said they felt there were good training opportunities available, and that they were able to access the training they needed. Staff training records supported this. The GP and the practice manager both said that there was protected learning time for staff. This was a city wide initiative and happened one afternoon every month. The sessions focussed on clinical learning, and sometimes they were based locally, although there was no specific in-house training.

We discussed poor staff performance with the practice manager. We were shown a policy for managing staff performance. The practice manager was clear that any issues with regard to staff performance would be managed. We discussed specific examples with the practice manager who was able to explain what action had been taken and the outcome. However, we saw that documents within the associated files had not been completed. The practice manager was unsure where the documentation was located.

Identification and management of risk

We found that significant events were discussed at staff meetings. However, the records did not always reflect the full discussion, and it was not clear that learning from significant events had taken place. Discussions with staff members showed that staff were aware of significant events that had occurred, however the documentation did not support this.

The practice had a business continuity and contingency plans in place. These would enable the service to continue to operate in the event of a failure of, for example, water supply or electrics to the building, or in severe adverse weather.

We saw that there were limited risk assessments in place related to health and safety. St Peter's Health Centre was owned by Leicestershire Partnership NHS Trust (LPT). We saw that as landlords they had carried out some health and safety risk assessments. However, the practice was unable to show us any health and safety risk assessments that they had produced themselves.

Older people

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

Our findings

In line with guidance from the British Medical Association (BMA) every patient over the age of 75 had a named GP. Older patients sometimes presented as being vulnerable, and the reception staff said they were aware of this. Older patients were offered the opportunity to have an appointment with a chaperone.

Within the waiting area there were leaflets relating to memory issues, and links with support services for older people. Staff said that there were links with local care homes for elderly people. Discussions with both staff and patients who fell into this population group identified that both thought their needs were identified and met by the practice.

The practice told us that they offer an appointment the same day, or a home visit where applicable. All patients aged 75 and above had been sent a letter informing them who their lead GP was.

People with long term conditions

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

Our findings

The practice operated a number of clinics for patients with long term conditions, such as patients with diabetes, leg ulcers and chronic obstructive pulmonary disease (COPD). Patients were kept under review, and there were systems for making referrals to other care agencies when required. Patients with long-term conditions were more likely to be receiving medication. The practice reviewed medication for these patients routinely every six months. Administrative staff at the practice were able to demonstrate how letters were routinely generated to invite patients for medication reviews. In addition they were able to show how patients were called and recalled to be seen about their condition.

The practice said that they offer patients with long-term conditions an annual review with the Practice Nurse. In addition patients have a blood test every six to twelve months depending on their condition. Where patients with long-term conditions were taking medication, the practice offered a medication review, with a face to face consultation so the patient has the opportunity to talk about the medicines they have been taking.

Mothers, babies, children and young people

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

Our findings

A specific GP at the surgery tended to deal with patients who fell into this category. This allowed for continuity and patients said they knew who they were seeing. The practice had a midwife working at the surgery every Tuesday. The practice also ran a vaccination clinic every Wednesday. The GP also handled advice about contraception, and this included access to the emergency morning after pill. Both patients and staff at the practice said they felt the needs of this patient group were catered for and met.

The practice said they offered postnatal services for new mothers, antenatal services for women during their pregnancies, contraception advice and the emergency morning after pill. The practice also ran an immunisation clinic.

Working age people (and those recently retired)

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

Our findings

To meet the needs of patients within this population group the practice opened late three times a week. Monday, Wednesday and Thursday until 8.00 pm. Patients aged 40 years and over were offered health checks. We saw that there was information available in the waiting area that would particularly relate to patients in this age group. For example smoking cessation and weight loss. The practice offered advice and support with smoking cessation.

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

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

Our findings

The practice had a lead GP for vulnerable groups of patients seen within the surgery. This included patients who had a learning disability, and people with mental health needs. Patients who were homeless or who were travellers had their health needs met at the Dawn Centre situated a few hundred yards away. Staff at the practice signposted patients from these vulnerable groups to the Dawn Centre. If a patient presented who was not registered at the practice looking for the morning after pill, they would be directed to family planning clinic on the 2nd floor. The practice said they had few patients with learning disabilities. These patients were known and communication was key to meeting their needs. In many cases the GP operated as a gateway for referral to more appropriate or specialist services. Discussions with staff at the practice identified that the needs of vulnerable patients were being met.

The practice said that there was the possibility for patients to register as a temporary patient if they are in Leicester for a short stay. In addition sex workers are offered the morning after pill, and referred on to the health centre. Patients who have a learning disability have a health review annually; in addition patients with a learning disability can see a GP on the same day. Patients with a learning disability also have their medication reviewed every six months.

People experiencing poor mental health

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

Our findings

Shefa Medical Practice does have some patients who have mental health needs. Reception staff said they try to treat all patients with respect, although sometimes patients with mental health needs arrive at the practice without an appointment. In these circumstances the reception staff would seek advice from a GP. Discussions with GPs at the practice identified that there were good networks between the practice and mental health services within the city. If a referral to another care provider or support agency was indicated this would be made.

Staff also told us that there were good links with the Maidstone Centre, which is where the Community Mental Health Team is based.

The practice said that there was a drive towards non-discrimination, with patients who had mental health issues treated equably. Annual blood tests were offered to all patients with mental health issues. GPs are aware of the changing nature of mental health, and medication is frequently reviewed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People who use services and others were not protected against the risks associated with inappropriate or unsafe care because National Institute for Health and Care Excellence (NICE) guidelines in respect of clinical analysis had not been followed.**