

Woodbrook Medical Centre

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 Woodbrook Medical Centre on 14 December 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system was in place for reporting and recording significant events.
- The practice had effective systems in place to safeguard children and vulnerable adults.
- Risks to patients were assessed and generally well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Regular clinical audits were undertaken within the practice to drive improvement.
- The practice worked effectively with the wider multi-disciplinary team to plan and deliver integrated care for patients with complex needs.
- Feedback from most patients was that they were treated with kindness, dignity and respect and were involved in decisions about their care.
- Most patients found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice continued to review access and sought to improve the level of service they offered to patients in response to patient feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision was regularly reviewed and discussed with staff.
- There was a clear leadership structure and staff felt supported by management.
- The practice reviewed and made changes to the way it delivered services as a consequence of feedback from patients and the patient participation group.
- The practice team was forward thinking and took part in local pilot schemes to improve outcomes for

Summary of findings

patients. This included setting up the musculoskeletal referral support service (MSK triage) in the local area and development of Cancer Maps, as an interactive reference tool for cancer guidelines.

The areas where the provider should improve:

- The practice should continue to ensure that action plans and improvements made from infection control audits are monitored and recorded.

- The practice should ensure plans in place for all staff to complete training at the recommended frequency determined by the provider are monitored.

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.

Good



- There was a system in place for reporting and recording significant events.
- When things went wrong patients were informed and received support, information and / or an apology. They were told about actions to improve processes to prevent the same thing happening again.
- The practice had systems and processes in place to ensure patients were kept safe and safeguarded from abuse. For example, medicines were managed safely and sufficient staff were recruited to meet the needs of patients.
- Risks to patients were assessed and generally well managed. The practice had identified the need to strengthen the systems in place for auditing infection control practices.
- The practice had adequate arrangements in place to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Patients' needs were assessed and care was planned and delivered in line with current evidence based guidance and legislation such as the Mental Capacity Act 2005.
- The practice had systems in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- One of the GP partners had mapped the NICE guidance and developed an innovative and interactive software tool that reviewed patient's cancer risk and considered the two week wait guidance. This software tool had been shared widely with other GPs.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the local and national averages. The most recently published results showed that the practice had achieved 98.5% of the total number of QOF points available compared to the CCG average of 96.9% and the national average of 95.4%.
- Clinical audits were undertaken within the practice to support improvement.

Summary of findings

- Staff had the skills and knowledge to deliver effective care and treatment. However, records reviewed showed some staff had not completed up to date training at the frequency determined by the practice.
- Staff worked with other health and social care professionals to understand and meet the range and complexity of patients' needs. This included engaging in regular multi-disciplinary meetings and coordinating the delivery of end of life care.

Are services caring?

The practice is rated as good for providing caring services.

Good



- We observed staff treating patients with kindness and respect, whilst maintaining patient and information confidentiality.
- Feedback from most patients highlighted they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The national GP patient survey results were mixed in respect of the satisfaction scores relating to the different staffing groups. For example, 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the local and national averages of 85%. Lower values were achieved for interactions with nurses and reception staff.
- Information for patients about the services and support groups available was accessible.
- The practice had a system in place for identifying carers and directing them to sources of support. A total of 158 carers had been identified and this represented 1.69% of the practice population.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team Clinical Commissioning Group to secure improvements to services where these were identified.
- A number of services were hosted within the practice to ensure care was delivered closer to home. This included the Citizens Advice Bureau, counselling services and a clinic facilitated by a mental health facilitator.
- GPs that were skilled in specialist areas such as dermatology and musculoskeletal conditions used their expertise to offer additional services to patients and acted as a resource for the clinical team.

Summary of findings

- Most patients said they generally found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The national patient survey results were mixed in respect of access to the service. For example, 89% of patients said their last appointment was convenient which was comparable to the local and national averages of 92%. Lower satisfaction scores related to patients' overall experience of making an appointment and telephone access. However, the practice continued to review access and sought to improve the level of service they offered to patients in liaison with the patient participation group.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed 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.

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. Policies and procedures were in place to govern activity and regular governance meetings were held.
- The provider was aware of the requirements of the duty of candour.
- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The patient participation group engaged with the practice and supported them to make improvements.
- There was a focus on continuous learning and improvement at all levels within the practice.
- As well as being a teaching and training practice for medical students and GP trainees, the practice was involved in research.

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.

Good



- Patients aged 75 years and over had a named GP to provide continuity of care.
- Home visits and urgent appointments were offered for older people with enhanced needs.
- The practice provided a weekly ward round at a local care home to manage chronic and acute conditions, with an added aim to avoid weekend hospital admissions.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs. Where older patients had complex needs, the practice shared summary care records with local care services.
- Influenza, pneumococcal and shingles vaccinations were offered in accordance with national guidance. A total of 73% of patients aged over 65 had received a flu vaccination which was in line with local and national averages.
- Nationally reported data showed that outcomes for conditions commonly found in older people, including rheumatoid arthritis and heart failure were in line with or above local and national averages.

People with long term conditions

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

Good



- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Patients at risk of hospital admission were identified as a priority and discussed at regular multi-disciplinary meetings to plan and deliver care appropriate to their needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- Nursing staff had lead roles in long-term disease management and worked in collaboration with community specialist nurses to deliver integrated care.

Summary of findings

- The practice monitored the needs of patients at risk of developing diabetes and facilitated patient education.
- Patients could book a double or triple appointment if they wished to be seen for complex and / or more than one medical issue.

Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and those at risk of abuse and deteriorating health.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Baby changing facilities were available and the practice accommodated mothers who wished to breastfeed.
- The use of telephone triage and a flexible appointment system ensured that children could be seen on the same day when this was indicated.
- The practice had emergency processes for acutely ill children and young people, and minor illness appointments were available on the same day with the nurse practitioner.
- A full range of contraception services were available including coil fitting, insertion and removal of contraceptive implants.

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 this population group had been identified and the practice had adjusted the services it offered to ensure they were accessible, flexible and offered continuity of care. For example, extended hours appointments were offered to facilitate access for working patients, and patients had access to same day appointments and telephone consultations.
- The practice was proactive in offering online services including appointment booking and online prescription services.

Good



Summary of findings

- A range of health promotion and screening services that reflected the needs of this age group was offered and promoted.
- The practice's uptake for the cervical screening programme was 96.1%, which was comparable to the CCG average of 98.8% and the national average of 97.3%.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and carers. Homeless people could also register with the practice.
- The practice offered longer appointments for patients with a learning disability and facilitated annual health checks.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Information was available which informed vulnerable patients about how to access local and national support groups and voluntary organisations.
- Translation services were provided where these were required.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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).

Good



- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The emotional needs of this population group was prioritised and patients had access to in-house counselling services and support from a mental health facilitator.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs and also followed up patients who had attended accident and emergency.
- 92% of patients with a mental health condition had a documented care plan in the last 12 months which was above the national average of 88% and below the local average of 94.5%.
- Patients at risk of dementia were identified and offered an assessment and staff carried out advance care planning for patients living with dementia.
- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months which was below the CCG average of 87% and national average of 84%.

Summary of findings

What people who use the service say

The national GP patient survey results were published in June 2016. Most of the results were comparable to the local and national averages; and lower satisfaction scores related to telephone access, experience of making an appointment and interactions with nurses and reception staff. A total of 257 survey forms were distributed and 108 were returned. This represented a 42% response rate and 1.2% of the practice's patient list.

- 87% of patients described the overall experience of this GP practice as good compared to the clinical commissioning group (CCG) and the national averages of 85%.
- 89% of patients said the last appointment they got was convenient compared to the CCG and national averages of 92%.

- 67% of patients described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%.
- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 78%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received four comment cards, three of these were positive about the standard of care received. Positive feedback related to the assessment of patients health needs and delivery of care and treatment. Staff were described as polite, courteous and approachable. Less positive comments related to care of mental health issues and not getting medicines as prescribed.

Areas for improvement

Action the service **SHOULD** take to improve

- The practice should continue to ensure that action plans and improvements made from infection control audits are monitored and recorded.
- The practice should ensure plans in place for all staff to complete training at the recommended frequency determined by the provider are monitored.

Woodbrook Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Woodbrook Medical Centre

Woodbrook Medical Centre provides primary medical services to approximately 9374 patients through a general medical services contract (GMS). The medical centre is located in the centre of Loughborough and the registered population lives in areas such as Quorn, Nanpantan, Hathern and Hoton.

The practice has been providing services from its current premises since 1986. The premises were extended in 1997 to enable the practice to expand the services offered. All patient services are provided on the ground floor of the building and this includes an attached pharmacy managed by an independent provider. The practice has limited car parking facilities and is accessible by public transport.

The registered patient population is predominantly of white British background and also includes a significant number of patients of Asian ethnicity (about 10%), Polish and Romanian nationals. The level of deprivation within the practice population is below the national average with the practice population falling into the sixth most deprived decile.

The clinical team comprises of five GP partners (three male and two female), a salaried GP (female), a nurse

practitioner, three practice nurses and two healthcare assistants. The clinical team is supported by a full time practice manager and a team of reception and administrative staff.

The practice is an approved teaching and training practice for medical students and GP trainees (a qualified doctor who is completing training to become a GP). At the time of inspection the practice had three GP trainees in post.

The practice opens from 8am to 6.30pm Monday to Friday and appointments are available within these hours. The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to contact the 111 service.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. This included West Leicestershire Clinical Commissioning Group. We carried out an announced visit on 14 December 2016. During our visit we:

Detailed findings

- Spoke with a range of staff (including GPs, nursing staff, the practice manager, reception and administrative staff)
- Observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- Reviewed four comment cards where patients shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

- Is it well-led?

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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.

Are services safe?

Our findings

Safe track record and learning

There were effective systems in place to report and record significant events.

- Staff told us significant events and incidents were reported to the practice manager or one of the GP partners in the first instance. A form would then be completed to record the details of the event or incident.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.
- We reviewed safety records, incident reports and minutes of meetings where significant events and case reviews were discussed. Records reviewed showed the practice carried out a thorough analysis of the significant events and after death analysis. Lessons were shared and action was taken to improve safety in the practice.
- Patients received an apology and appropriate support when there had been an unintended or unexpected incident. We found the practice would either meet with the patient concerned or write to them, depending on the nature of the concern. Patients were also told about the action taken to improve processes to prevent the same thing happening again.
- The practice undertook an annual review of significant events to evaluate the follow-up action taken and to ensure improvements had been embedded.

The practice had a process to review patient safety alerts received including those from the Medicines Health and Regulatory Authority (MHRA). MHRA alerts were cascaded to all relevant clinicians and patient searches were undertaken to identify which patients may be affected. The GPs took action to ensure patients were safe, for example, by reviewing their prescribed medicines.

Overview of safety systems and processes

The practice had systems and procedures in place to keep people safe and safeguarded from abuse.

- Arrangements for safeguarding children and vulnerable adults reflected relevant legislation and local

requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding children and vulnerable adult. Regular meetings were held with the health visitor to discuss children at risk of deteriorating health and / or abuse. Staff we spoke with demonstrated they understood their responsibilities and most staff had received up to date safeguarding training that was relevant to their role. GPs were trained to child protection or child safeguarding level three.

- Notices were displayed in the waiting area and in consultation rooms to advise patients that they could request a chaperone if required. A practice nurse, a health care assistant or the senior receptionist would act as a chaperone if this was requested by the patient. All staff who acted as chaperones had received training for the role and had a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The nurse practitioner was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice.
- There was an IPC protocol and records reviewed showed most staff had received up to date training.
- Infection control audits were periodically undertaken and action was taken to address any areas identified for improvement.
- The practice had recently strengthened its infection control practices having recognised a systematic approach was required to ensure audits were undertaken regularly and the resulting action plans were to be monitored, updated and recorded.

Are services safe?

Medicines management

The arrangements for managing medicines in the practice including vaccinations minimised risks to patient safety. This included arrangements for obtaining, prescribing, recording, handling, storing, security and disposal.

- The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Vaccinations and medicines in stock were regularly checked including their expiry dates.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- The practice had systems in place for monitoring high risk medicines and the frequency at which patients required blood monitoring. Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the GPs for this extended role.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines against a specific patient specific direction from a prescriber.
- The practice held stocks of a controlled drug (a medicine that requires extra checks and special storage because of their potential misuse) and procedures were in place to manage them safely. Following our feedback on the inspection day, the practice ensured the controlled drug registers were bound and not loose leaf in line with recommended guidance. There were also arrangements in place for the destruction of controlled drugs.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

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

- The practice had a health and safety policy in place and fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a prominent position.
- An up to date fire risk assessment was in place and records reviewed showed most staff had completed fire marshal and safety training.
- We saw evidence of fire drills and fire safety equipment checks being undertaken periodically. This included fire alarms, emergency lighting and extinguishers being tested and serviced regularly to ensure they were in full working order.
- All electrical and clinical equipment was checked to ensure it was safe to use and in good working order. The most recent portable appliance testing and calibration of equipment had been undertaken in August 2016.
- The practice had a variety of other risk assessments to monitor the safety of the premises. This included control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements in place for planning and monitoring the number and skill mix of staff needed to meet patients' needs. This included the use of a rota system for all the different staffing groups to ensure enough staff were on duty. The practice also reviewed the demand for services and adjusted the staffing levels or availability when required. For example, clinicians saw additional patients within their administration time to help ease pressure with appointments.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Are services safe?

- All staff received basic life support and first aid training to ensure they could respond to medical emergencies. The nursing staff including healthcare assistants had also undertaken anaphylaxis training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.
- All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. Copies of the plan were held off site and the plan included emergency contact numbers for staff and suppliers.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed the needs of patients and delivered care in line with relevant and current evidence based guidance and standards. This included the National Institute for Health and Care Excellence (NICE) best practice guidelines and local prescribing guidelines.

- The practice had systems in place to keep all clinical staff up to date. For example, a GP lead reviewed any new or revised guidance and the updates were discussed at the regular clinical meetings.
- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments and audits of patient records.
- One of the GP partners had produced an interactive mind mapping software as an interactive reference tool for NICE guidelines. The software allows clinicians to input the patient's symptoms or test results and it will highlight possible cancers to consider and suggest further management. The software had also been shared more widely within the local area and at a workshop organised by Cancer Research UK and the Royal College of General Practitioners. About 32 GPs had attended the workshop and feedback received was positive about the impact it had on the clinicians' knowledge and understanding of the guidelines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98.5% of the total number of points available compared to the clinical commissioning group (CCG) average of 96.9% and national average of 95.4%.

The clinical exception reporting rate was 14.4% which was above the CCG average of 9.6% and the national average of 9.8%. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment.

This practice was not an outlier for any QOF (or other national) clinical targets. The 2016 QOF data showed:

- Performance for diabetes related indicators was 97.5% which was above the CCG average of 93.1% and the national average of 89.8%. This was achieved with a high exception reporting rate of 16% compared to the CCG average of 10.5% and the national average of 12%.
- Performance for hypertension related indicators was 100% which was above the CCG average of 98.3% and the national average of 97.3%. This was achieved with a high exception reporting rate of 13% which was above the CCG and national averages of 4%.
- Performance for dementia health related indicators was 100% which was above the CCG average of 97.7% and the national average of 96.6%. This was achieved with an exception reporting rate of approximately 19% which was above the CCG average of 17% and the national average of 13%.
- Performance for mental health related indicators was 98.7% which was above the CCG average of 96.9% and national average of 92.8%. This was achieved with an exception reporting rate of 20% which was below the CCG average of 21.5% and above the national average of 11%.

The QOF data showed exception reporting was above the local and national averages for some clinical indicators. Records reviewed and discussions held with practice staff showed the decision to exception report was based on appropriate clinical judgement with clear and auditable reasons coded or entered in free text on the patient record. Examples of exclusions included:

- Patients who had not attended their health reviews in spite of being invited on three occasions.
- Patients for whom prescribing a specific medicine or treatment was not clinically appropriate and / or
- Patients newly diagnosed or who had recently registered with the practice who should have had measurements made within three months.

Are services effective?

(for example, treatment is effective)

There was evidence of quality improvement including clinical audit.

- There had been 19 clinical audits undertaken in the last two years, six of these were completed audits where the improvements made were implemented and monitored.
- Findings were used to improve practice and patient outcomes. This included improving the monitoring of blood pressure. Two of the GP partners were trained in dermatoscopy and they audited their interventions. Evidence reviewed showed a reduction in the number of inappropriate two week wait referrals and appropriate referrals were made to secondary care when needed.
- The practice had taken steps in relation to medicines optimisation. This included monitoring the quality of prescribing, adherence to the prescribing formulary and carrying out clinical audits using quality improvement tools such as Pincer. The Pincer tool is used to identify at risk patients who are prescribed drugs that are commonly and consistently associated with medication errors so that corrective action can be taken to reduce the risk of reoccurrence of these errors.
- The practice had one of the lowest prescribing rates for antibiotics in the locality. Prescribing data as at June 2016 showed the percentage of antibacterial prescription items prescribed was 2.91% which was lower than the CCG average of 3.73% and national average of 4.71%.
- The practice participated in local benchmarking activities facilitated by the CCG. For example, the benchmarking data as at September 2016, showed patients use of secondary care / hospital services were below the CCG average. This included accident and emergency attendances, emergency and elective admissions, outpatient attendances and the number of frequent attenders.
- Staff had access to appropriate training to cover the scope of their role and made use of e-learning training modules and in-house training. However, records reviewed showed some staff had not completed up to date training at the frequency determined by the practice. This had been identified as an area of improvement and plans were in place to address this.
- Staff told us that they received an annual appraisal and we saw documentation that evidenced this.
- The practice ensured relevant staff were supported with role-specific training and refresher training to update their knowledge. This included clinicians reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- Supervisory and peer support arrangements were in place, monitored and reviewed for clinicians involved in delivering care and treatment. This included monthly meetings for GPs and nurses, and support was provided for revalidation with the Nursing Midwifery Council and the General Medical Council. Revalidation is a scheme to provide assurance that clinicians have kept up-to-date with their practice and can demonstrate they work within recognised quality standards.
- A support structure was in place for supervision which included one to one sessions or group meetings. This included daily mentor and debrief sessions to support GP trainees in their roles.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records, investigation and test results. Systems were in place to ensure incoming and outgoing correspondence was managed effectively.
- Records reviewed showed relevant information was shared with other services in a timely way, for example when referring patients to secondary care.
- The GPs and nurses met informally for coffee at the end of morning surgery for clinical discussions and information sharing. This also included the review of referrals.

Effective staffing

Staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. In addition to role-specific induction, general topics such as safeguarding, health and safety, information governance and confidentiality were covered.

Are services effective?

(for example, treatment is effective)

Practice staff worked with other health and care professionals to meet the range and complexity of people's needs and to assess and plan their ongoing care and treatment. This included when patients were moved between services, referred to hospital or after they were discharged. Information was shared between services, with patients' consent, using a shared care record.

Multi-disciplinary meetings took place on a monthly basis and care plans were routinely reviewed and updated for patients with complex needs. The meetings were attended by the Macmillan nurse and virtual ward nurse for example, and agenda items included the review of patients with a new cancer diagnosis, after death analysis, case reviews and feedback on referrals made.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and on-going conversations with these patients about their end of life care as part of their wider treatment and care planning. There was evidence this was having a positive impact as the CCG benchmarking data as at September 2016 showed the practice had one of the lowest emergency admission rates for patients receiving end of life care (0.47 per 1000 patient population) compared to the CCG average of 1.10 per 100 patient population.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services.

- This included patients at risk of developing a long-term condition, those requiring advice on their diet, smoking and alcohol cessation and those who were homeless. Patients were offered services from the practice, referred or signposted to the relevant service.
- The practice facilitated an annual flu campaign (including a Saturday clinic). Benchmarking data as at April 2016 showed the uptake of the flu vaccination for patients aged over 65 was 73% which was in line with local and national averages. Flu vaccination rates for 'at risk' patients aged under 65 was at approximately 56% which was above the local average of 51% and national average of 53%.
- The practice had been involved in setting up the local exercise referral scheme in collaboration with a local gym. Data showed the practice was one of the highest referrers for this scheme in the locality.
- The practice provided new patient health checks and NHS health checks for patients aged 40 to 74 years old. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- The practice had undertaken an annual health review for 27 out of 44 (61%) of their patients on the learning disabilities register in the last 12 months. The practice had identified this as an improvement area and a designated nurse was to carry out additional health checks post our inspection.
- Childhood immunisations were carried out in line with the national vaccination programme. The 2015/16 uptake rates for the vaccines given were above or comparable to the CCG and national averages. For example, the rates for the vaccines given to under two year olds ranged from 95.2% to 98.9% and five year olds from 90.2% to 96.1%.
- The practice's uptake for the cervical screening programme was 96.1%, which was comparable to the CCG average of 98.8% and the national average of 97.3%. Reminders were offered for patients who did not attend for their cervical screening test. The practice encouraged the uptake of the screening programme

Are services effective?

(for example, treatment is effective)

and they ensured a female sample taker was available. There were effective systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. The practice's uptake rate for breast cancer screening was 77% which was below the CCG average of

81% and above the national average of 72.5%. The uptake rate for bowel cancer screening was 55% which was below the CCG average of 63% and the national average of 58%. The practice were aware of the low uptake rates and had action plans in place to address this. This included patient education and sending a personalised letter of support for the new flexible sigmoidoscopy screening. Sigmoidoscopy is a procedure that lets the GP or nurse look inside the sigmoid colon by using a flexible tube with a light on it.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

Three out of four patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they found staff approachable, polite and willing to help.

Feedback from the patient survey, compliments and friends and family test results showed most patients were satisfied with the care provided by the practice. Patients said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

The national GP patient survey results showed patients felt they were treated with compassion, dignity and respect. The practice was above average for most of its satisfaction scores on consultations with GPs. For example:

- 94% of patients said they had confidence and trust in the last GP they saw compared to the clinical commissioning group (CCG) and national averages of 95%.
- 89% of patients said the GP was good at listening to them which was in alignment with the CCG and national averages.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national averages of 85%.

- 80% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.

The practice was below average for most of its satisfaction scores on consultations with nurses and interactions with reception staff. However, we were assured that the practice was committed to analysing and addressing the areas in liaison with the patient participation group. This included facilitating staff training and awareness to improve the care delivered.

- 97% of patients said they had confidence and trust in the last nurse which was in alignment with the CCG and national averages.
- 89% of patients said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 85% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the local and national averages of 91%.
- 84% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 77% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

We also looked at the practice's own patient survey results published in March 2016. A total of 220 questionnaires had been completed and the results showed a high level of satisfaction with the care received from receptionists (99%). Similarly, the practice survey results relating to nurses showed satisfaction scores of between 94% and 98%.

Care planning and involvement in decisions about care and treatment

Most of the patient feedback we reviewed showed patients felt involved in decision making about the care and treatment they received. They also felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was mostly positive and aligned with these views. Less positive comments related to the care of a patient with mental health needs.

Are services caring?

We saw examples of personalised care plans and action plans provided to patients. For example, patients receiving care and support from the heart failure and respiratory specialist nurses were given a care plan. These plans took account of the individual needs and circumstances of the patient.

The national GP patient survey results showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 82%.
- 90% of patients said the last nurse they saw was good at explaining tests and treatments which was in alignment with the CCG and national averages.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care which was slightly below the CCG average of 86% and the national average of 85%.

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

- Although the vast majority of patients had English as a first language, staff told us that translation services were available for patients who did not have English as a first language.
- Some information leaflets were available in easy read format and large font.

Patient and carer support to cope emotionally with care and treatment

A wide range of patient information leaflets and posters were available in the patient waiting area. These informed patients about how to access a number of local and national organisations which could offer support. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 158 patients as carers which represented 1.69% of the practice list. The practice's registration form asked patients with caring responsibilities to record this to ensure the practice could offer carers appropriate support. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them where appropriate. Where required, this contact was followed by a consultation at a flexible time to meet the family's needs or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and West Leicestershire Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, about 600 patients (6.4% of the practice population) were identified as being at high risk of developing pre-diabetes and had received a review of their health needs including patient education. Some of these patients were also participating in the "Lets prevent diabetes" which is a study looking at whether an educational lifestyle programme (of diet and exercise) can prevent people going on to develop diabetes. In addition, the practice was part of the local federation of GP practices which aimed to improve and increase local services.

The practice understood its population profile and had used this understanding to meet the needs of its population. A range of services were planned and delivered to ensure flexibility, choice and continuity of care. For example:

- A wide range of clinics for chronic disease management and treatment room services were provided for patients. This included a phlebotomy service (including paediatric venepuncture), dressings, ear syringing and spirometry (a test used to help diagnose and monitor certain lung conditions).
- Patients with complex health needs had access to community based specialist nurses for conditions such as diabetes and heart failure. This enabled patients to access care closer to home and the joint working arrangements increased the skills of practice nurses in managing these patients.
- Minor surgery and joint injections were offered at the practice which reduced the need for patients to travel to access these services.
- GPs that were skilled in specialist areas such as dermatology and sports injury used their expertise to offer additional services to patients and acted as a resource for the clinical team. For example, patients had access to musculoskeletal (MSK) clinics which were delivered by one of the GP partners with a special

interest in this area. Benefits to patient included improved access to treatment by reducing the need for them to be referred externally and be seen as outpatients.

- A number of services were hosted within the practice to ensure care was delivered closer to home. This included access to the Citizens Advice Bureau, an in-house counselling service and a clinic facilitated by a mental health facilitator.
- The practice had close links with one local care home and named GPs conducted regular 'ward rounds' on Friday and follow-up visits on a Monday. Care home staff liaised with a nominated member of the reception staff to ensure older people received coordinated care and support when needed.
- The practice offered access to a full range of family planning services including long-acting reversible contraceptives such as injections, intrauterine devices (coils) and subdermal contraceptive implants.
- Ante-natal appointments were available weekly with the attached community midwife. The practice provided neonatal checks, six week post-natal checks for new mothers and eight week baby checks.
- The practice was a registered yellow fever centre and patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- A range of online services were available including online appointment booking and prescription ordering.
- The practice had considered and implemented the NHS England Accessible Information Standard to ensure patients received information in a format they could understand and appropriate support was provided to help them to communicate their needs.
- There were accessible facilities which included a hearing loop, baby changing facilities and all patient services were delivered on the ground floor.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were available within these times. Extended hours appointments were offered from 7.30am to 7pm on some days subject to patient demand. Patients could telephone the practice between 8am and 10.30am to access a same day appointment with a clinician. Patients

Are services responsive to people's needs?

(for example, to feedback?)

were encouraged to contact the practice after 10.30am or to utilise the online booking system for requesting pre-bookable appointments. Patients experiencing a minor illness had access to daily appointments with a nurse.

The practice operated a triage system which enabled the practice staff to assess the urgency of the need for medical attention. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. This included referring patients to the paramedic led acute visiting service if an urgent home visit was requested or hospital admission was indicated. Each GP had a daily triage list which enabled patients to access their own GP for advice or review. In addition, a "duty team" comprising of a GP and nurse responded to all acute health needs on the same day they were raised.

Patient feedback showed most people were able to get appointments when they needed them. The national GP patient survey results showed that patients' satisfaction with how they could access care and treatment was mixed. For example:

- 89% of patients said their last appointment was convenient compared to the CCG and national averages of 92%.
- 80% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 86% and the national average of 85%.
- 72% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 52% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 58%.

However, 67% of patients described their experience of making an appointment as good compared to the CCG

average of 72% and the national average of 73%. In addition, 58% of patients said they could get through easily to the practice by phone compared to the CCG average of 71% and the national average of 73%.

The practice and the patient participation group were aware of the lower satisfaction scores and this was an area kept under review. Different systems had been trialled in an attempt to improve access. This included improving the telephone system to filter calls better and increasing the number of available appointments online and staff answering the phone.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. This included the display of posters and summary leaflets.

We looked at complaints received in the last 12 months and found these were satisfactorily handled and dealt with in an open and transparent manner. The practice offered to meet with complainants to discuss their concerns whenever this was deemed appropriate. Records reviewed showed explanations and apologies were provided to patients. Lessons were learnt from individual concerns and complaints, and action was taken to improve the quality of care. The practice had looked at eight complaints as part of their annual review to ensure follow-up action had been completed and improvements had been sustained.

Are services well-led?

Good 

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

Our findings

Vision and strategy

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

- Staff were engaged with the practice vision and were aware of the importance of their roles in delivering it. This included providing patient centred care and working together as a cohesive team.
- The vision and mission statement for the practice was shared with patients in practice information leaflets and on the practice website.
- Weekly business meetings were attended by the GPs, GP trainees and the practice management to review the service provision and business matters.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities. GPs had lead roles in key areas such as patient liaison, finances, clinical and information governance.
- The practice also engaged the services of an external company to inform their human resources processes.
- Practice specific policies were implemented and available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. This included monitoring of clinical outcomes for patients and patient satisfaction.
- The practice was well engaged with local GP practices and the local clinical commissioning group (CCG), and worked with them to drive improvements in performance.
- Practice meetings were held regularly which provided an opportunity for staff to learn about the performance of the practice.

- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The GP partners and practice manager had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us the leadership team was visible in the practice, approachable and took the time to listen to them.

The partners encouraged a culture of openness and honesty. For example, the provider had systems to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Some of the GP partners held strategic roles within the CCG and regional area. This enabled them to influence decision making and commissioning of services for the benefit of the practice population and the wider community. For example, one of the GP partners was the locality lead for musculoskeletal conditions and another GP partner was the cancer lead for the East Midlands cancer clinical network, which promotes best practice and equality of treatment.

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

- A wide range of meetings were held within the practice on a regular basis. These included clinical meetings, referral meetings and whole staff team meetings.
- Staff told us they were able to raise issues for discussion at meetings and felt confident and supported in doing so.
- Staff we spoke with felt involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good 

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

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice gathered feedback from patients through the patient participation group (PPG), surveys and complaints received.
- The PPG had a membership of eight patients who attended monthly meetings in the practice. The PPG produced the practice newsletter, engaged in fundraising activities and submitted proposals for improvements to the practice management team. For example, the PPG had been involved in working with the practice to make improvements to the telephone system and promoting the availability of online services.
- The PPG was also a member of the locality and federation group and members attended the meetings which provided an opportunity to network and share learning.
- The GP partners encouraged and valued staff feedback. Feedback was gathered from staff meetings, appraisals and discussions. Staff told us their feedback was listened to and acted upon by the management team.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice

team was forward thinking and took part in a number of local pilot schemes to improve outcomes for patients. For example, the practice was involved in the musculoskeletal referral support service (MSK triage) in the CCG area. This service was provided by one of the GP partners in collaboration with another local GP and a consultant orthopaedic surgeon. This pilot aimed to:

- reduce the amount of time that patients wait for help with musculoskeletal conditions, problems that affect the muscles, bones, and joints.
- provide services close to patients' homes and
- to reduce the time that GPs spend assessing MSK-related conditions.

There was a strong focus on education and development within the practice. The practice was a teaching and training practice for medical students and GP trainees. Records reviewed showed the medical students and GP trainees had a positive learning experience including support.

One of the GP partners had been supported to pursue interests related to cancer care for the benefit of patients. The GP partner is the author of cancer maps, an interactive reference tool for the NICE NG12 guidelines. The cancer maps tool is being piloted as part of the East Midlands Cancer Clinical Network and is planned for use nationwide in liaison with Cancer Research UK. The practice was also involved in research and the quality, innovation, productivity and prevention (QIPP) programme.