Latham House Medical Practice

Quality Report

Sage Cross Street,
Melton Mowbray,
Leicestershire
LE13 1NX
Tel: Tel: 01664 503000
Website: www.lhmp.co.uk

Date of inspection visit: 7 December 2016
Date of publication: 13/04/2017

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the practice on 16 April 2015. A breach of legal requirements was found. After the comprehensive inspection the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach of Regulation 12, 13 and 18.

The purpose of this comprehensive inspection was to ensure that sufficient improvement had been made following the practice being given an overall rating of Requires Improvement as a result of the findings at our inspection on 16 April 2015. We also checked that they had followed their action plan from the last inspection and to confirm they now met their legal requirements.

Following this most recent inspection we found insufficient improvements had been made and in some areas had deteriorated which has resulted in the practice being given an overall rating of inadequate. Safe and Well-led are inadequate, Responsive is rated as requires improvement. Effective and Caring is rated as good.

- Since our inspection in April 2015 there had been further changes in leadership and although there was a new vision and strategy there was still a lack of accountable, visible leadership.
- The process for safeguarding service users from abuse had been reviewed and was now effective.
- Patients were at risk of harm because some systems and processes in place were not effective to keep them safe. For example, in the areas of significant events, safety alerts infection control, monitoring of patients on high risk medicines and complaints.
- Risks to patients were not assessed and well managed.
- The system in place to monitor the training of the GPs and staff within the practice was not effective. For example, not all clinical staff had received appropriate training in safeguarding to ensure they were up to date with current procedures.
- Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
  - Patients were positive about their interactions with staff and said they were treated with compassion and dignity.
  - Comment cards were positive about the standard of care received. They identified that staff were caring, polite, respectful and professional.
  - The practice had recently introduced urgent care appointments every morning which were led by a GP and nurse team. These appointments were for patients who wanted to be seen on the day.
  - There was a limited governance framework to support the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

The areas where the provider must make improvements are:

- Improve the process in place for the management of risks to patients and others against inappropriate or unsafe care. This should include reporting, recording, acting on and monitoring significant events, incidents, near misses, patient safety alerts, infection control, monitoring of patients on high risk medicines and complaints.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Implement governance arrangements to ensure appropriate systems are in place for assessing and monitoring the quality of services provided.
- Ensure recruitment arrangements include all necessary employment checks for all staff and are in line with Section 3 of the Health and Social Care Act 2008.
- Improve the process in place to ensure staff training is monitored and all staff are up to date with mandatory training.
- Ensure CQC registration is up to date and correct in regard to registration of the practice.
- Ensure an updated statement of purpose is in place and submitted to the Care Quality Commision.

The areas where the provider should make improvements are:

- Ensure actions from infection control audits are recorded and implemented.
- Within the Business Continuity Plan ensure mitigating risks and actions are included.
- Review and embed the current process to ensure that fridge temperatures at the Asfordby branch surgery are reset in line with practice policy.
- Improve the system in place for exception reporting.
- Put a system in place to ensure prescription stationery is dealt with in line with national guidance.
- Address the issues highlighted in the national GP survey in order to improve patient satisfaction, including in respect of appointment access.
- Ensure all staff have a yearly appraisal.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Following this most recent inspection we found insufficient improvements had been made and in some areas had deteriorated
- The process for safeguarding service users from abuse had been reviewed and was now effective with the exception of gaps in safeguarding training.
- Patients were at risk of harm because systems and processes currently in place to keep them safe were not effective.
- The process for significant events required improvement,
- The process for safety alerts did not ensure patients were kept safe.
- Monitoring of high risk medicines had been reviewed but further work was required.
- Risk were not assessed and well managed. For example, main premises, Asfordby branch, fire and legionella.
- The systems and processes in place in regard to infection control required further improvement. For example, the action plan from the recent infection control audit and the documentation of cleaning spot checks.

Are services effective?

Good

The practice is rated as Good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was limited evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes.
- The practice did not have an effective system in place to monitor training. Therefore we could not be assured that staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was limited evidence of appraisals for most of the staff groups within the practice

Summary of findings

Are services caring?

Good

The practice is rated as Good for providing caring services, as there are areas where improvements should be made.

- The July 2016 national GP patient survey information we reviewed showed mixed results by patients for the emotional support provided by the practice. For example: 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 88% of patients who responded to the national patient survey said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, urgent care access clinics being run every morning for patients who needed to be seen on the day.
- Results from the July 2016 national GP patient survey showed that patient's satisfaction with how they could access care and treatment were below local and national averages.
- 67% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 56% of patients said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 73%.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice did not have an effective complaints system in place.
- There was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

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

Summary of findings

- Although the partners were positive about future plans, we found a lack of leadership and governance relating to the overall management of the service. The practice was unable to demonstrate strong leadership in respect of safety.
- There was a limited governance framework which supported the delivery of the strategy and good quality care.
- There were no robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions for the main practice and the branch surgery.
- The practice did not have a clear or consistent system in place for reporting, recording and monitoring significant events, incidents and complaints.
- The practice had a programme of continuous quality improvement but completed clinical audits did not demonstrate improvement in performance to improve patient outcomes.
- The practice did not have a robust process in place for the blank prescription forms for use in printers to be tracked through the main practice or the branch surgery.
- All staff had received inductions but not all staff had received regular performance reviews or attended staff meetings and events.
- The practice did not have an effective system in place to monitor the training of the GPs and clinical staff within the practice.
- There was no evidence that learning from significant events and complaints had been shared with staff.
- The practice had a number of policies and procedures to govern activity. Most had been reviewed but some still required the person responsible to be included.

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

Inadequate 

We carried out an announced comprehensive inspection of the practice on 16 April 2015. A breach of legal requirements was found. After the comprehensive inspection the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach of Regulations 12, 13 and 18.

This inspection took place on 7 December 2016 to check that they had followed their action plan and to confirm they now met their legal requirements. Following this most recent inspection we found overall the practice was now rated as Inadequate. Safe and Well-led was now inadequate, Responsive requires improvement. Effective and Caring is rated as good. These ratings applied to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- 26% of the practice population were older people.
- Each of the eight care homes where patients lived who were registered with the practice had a named GP.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 87.4% which was 4.6% above the CCG average and 4.5% above the national average. Exception reporting was 4.8% which was 0.7% below the CCG average and 0.9% below national average.
- The practice had recently introduced a nurse led education group for patients who had recently been diagnosed with hypertension.
- Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.
- The practice had a branch surgery at Asfordby which gave older people the opportunity to be seen by a GP without having to travel.

Summary of findings

People with long term conditions

Inadequate

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The practice is rated as inadequate for the care of long term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 92.7% which was 2.1% above the CCG average and 1.4% above the national average. Exception reporting was 5.3% which was 0.6% below CCG average and 0.2% below national average.
- The practice described themselves at the forefront of diabetes care in the community. A team of diabetic nurse specialists offered easily accessible care for patients with diabetes.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that includes an assessment of asthma was 70.1% which was 3.5% below the CCG average and 5.4% below the national average. Exception reporting was 13.3% which was 1.4% above the CCG average and 5.4% above national average.
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional was 93.8% which was 6.1% above the CCG average and 4.2% the national average. Exception reporting was 11.5% which was 3.4% below the CCG average and the same as the national average.
- 98% of patient who had four or more medicines on repeat prescription had received a review in the last 12 months.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and 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.

Families, children and young people

Inadequate

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

- There were some systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances.
- Immunisation rates for the standard childhood immunisations were mixed. Results were 91-96% for one to two years olds and 89% to 96% for five year olds against a CCG average of 95%.
- Appointments were available outside of school hours. Extended hours appointments were available
- The practice's uptake for the cervical screening programme was 76.6%, which was comparable to the CCG average of 78% and the national average of 74%.
- The practice ran a successful CHAT (confidential health advice for teenagers) clinic. This was advertised on a board in suite five, and in other places in the practice. It was a drop in service offered by nurses. It included general health advice, contraception advice, STI screening, pregnancy testing, emergency contraception and chlamydia screening. This service was well advertised in the practice and in the local schools.
- The practice had a branch surgery at Asfordby which gave parents of families, children and young people the opportunity to be seen by a GP without having to travel.

Summary of findings

Working age people (including those recently retired and students)

Inadequate

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This inspection took place on 7 December 2016 to check that they had followed their action plan and to confirm they now met their legal requirements. Following this most recent inspection we found overall the practice was now rated as Inadequate. Safe and Well-led was now inadequate, Responsive requires improvement. Effective and Caring is rated as good. These ratings applied to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of working-age people (including those recently retired and students).

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

People whose circumstances may make them vulnerable

Inadequate

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This inspection took place on 7 December 2016 to check that they had followed their action plan and to confirm they now met their legal requirements. Following this most recent inspection we found overall the practice was now rated as Inadequate. Safe and Well-led was now inadequate, Responsive requires improvement. Effective and Caring is rated as good. These ratings applied to everyone using the practice, including this population group.

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

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had 337 patients on the palliative care register. 100% had received an annual review.
- The practice offered longer appointments for patients with a learning disability.
- 59.5% of patients with a learning disability had received a review in the last 12 months.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Inadequate

We carried out an announced comprehensive inspection of the practice on 16 April 2015. A breach of legal requirements was found. After the comprehensive inspection the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach of Regulations 12, 13 and 18.

This inspection took place on 7 December 2016 to check that they had followed their action plan and to confirm they now met their legal requirements. Following this most recent inspection we found overall the practice was now rated as Inadequate. Safe and Well-led was now inadequate, Responsive requires improvement. Effective and Caring is rated as good. These ratings applied to everyone using the practice, including this population group.

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia).

- The practice had 248 registered with poor mental health. 79% had received an annual physical health check in the last 12 months.
- The practice had 305 patients for patients registered with dementia. 69.5% had received an annual review. Until recently a lead nurse at the practice visited patients with dementia

annually in their own homes, to ensure a review of all their needs was undertaken. This role was currently vacant but we were told that the practice had plans in place to recruit a replacement.

- The practice had 714 patients for patients registered with a depression. 79% had received an annual review.
- The practice had four doctors with specialist training in substance misuse and work with a tertiary service to provide care for this group of patients. The patients were under the shared care substance misuse scheme. This enabled them to obtain all their medical services from one location. They had 56 patients registered and 78% had received an annual review. Monthly meetings took place and all patients currently registered for this scheme were regularly discussed.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing below local and national averages. 247 survey forms were distributed and 110 were returned. This represented 0.7% of the practice's patient list.

- 56% of patients found it easy to get through to this practice by phone compared to the CCG average of 67% and the national average of 73%.
- 85% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%.
- 86% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 86% 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 78% and the national average of 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 31 comment cards which were positive about the standard of care received. Patients who completed these cards told us that they received excellent care, doctors and staff were prompt, caring, courteous and friendly. Six of these cards had a negative element but no common theme or trend.

We spoke with the chairperson of the patient reference group (PRG). The PRG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The PRG chair told us they meet on a monthly basis but had additional meetings as required. The chairperson told us that they worked well with the practice and were developing action plans to address issues patients had raised. They also told us that the practice gave the health service a human face and cared about the people who came through the door.

Areas for improvement

Action the service MUST take to improve

- Improve the process in place for the management of risks to patients and others against inappropriate or unsafe care. This should include reporting, recording, acting on and monitoring significant events, incidents, near misses, patient safety alerts, infection control, monitoring of patients on high risk medicines and complaints.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Implement governance arrangements to ensure appropriate systems are in place for assessing and monitoring the quality of services provided
- Ensure recruitment arrangements include all necessary employment checks for all staff and are in line with Section 3 of the Health and Social Care Act 2008.
- Improve the process in place to ensure staff training is monitored and all staff are up to date with mandatory training.
- Ensure CQC registration is up to date and correct in regard to registration of the practice.
- Ensure an updated statement of purpose is in place and submitted to the Care Quality Commission.

Action the service SHOULD take to improve

- Ensure actions from infection control audits are recorded and implemented.
- Within the Business Continuity Plan ensure mitigating risks and actions are included.

Summary of findings

- Review and embed the current process to ensure that fridge temperatures at the Asfordby branch surgery are reset in line with practice policy.
- Improve the system in place for exception reporting.
- Put a system in place to ensure prescription stationery is dealt with in line with national guidance.
- Address the issues highlighted in the national GP survey in order to improve patient satisfaction, including in respect of appointment access.
- Ensure all staff have a yearly appraisal.

Latham House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a second CQC inspector, GP specialist adviser, a practice manager specialist adviser and a practice nurse specialist advisor.

Background to Latham House Medical Practice

Latham House Medical Practice provide primary medical services to a population of approximately 35,521 registered patients in Melton Mowbray, Leicestershire. Latham House Medical Practice is one of the largest single group practices in the country. They cover a seven mile radius of Melton Mowbray. The Practice encourage their clinicians to have specialist areas of interest and they offered patients the opportunity to be on a particular doctors list so that patients can forge long lasting relationships with the doctor of their choice. A branch surgery at Asfordby provides a local service for patients who preferred not to travel to the main surgery in Melton Mowbray.

Latham House Medical Practice has a main reception as you entered the building. There were reception areas for each of the GP suites which were well signposted and each had their own telephone line.

Latham House Medical Practice was open from 8.30am to 6.30pm. A duty doctor was on site from 8am to 8.30am and 6pm to 6.30pm. Appointments were available at various times between: 8.30 am - 5.30 pm at the main site at Melton Mowbray and in the mornings at the Asfordby branch surgery. Extended hours appointments were also available Mondays from 7.40am to 7.50am and from 6.30pm to 6.40pm, Thursdays 6.30pm to 6.40pm.

The practice had a nurse led minor treatment unit (MTU) which was open from 8.30 am to 6.00 pm. This was a walk in service for any minor injury sustained within 48 hours.

The practice had recently introduced urgent care appointments led by a GP and nurse team every morning which were for patients who wanted to be seen on the day. The practice continued to have nurse led Immediate Access Clinics in the afternoon which also provided access for patients who requested an urgent or 'same day' appointment.

The practice had separate areas for administrative and clerical staff. These included staff taking phone calls, repeat prescriptions, new patients who want to register, patients who were referred through choose and book, secretaries and coders of medical notes

At the time of our inspection the practice employed 15 GP partners, five salaried GP's (14 WTE) , one practice manager, one contracts and performance manager, one reception manager, one maintenance manager, one IT manager, 22 practice nurses (18 WTE) and 65 administration staff (which included staff taking phone calls, repeat prescriptions, new patients who want to register, patients who were referred through choose and book, secretaries and coders of medical notes

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

Detailed findings

The practice's services were commissioned by East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG).

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

Latham House Medical Practice, Sage Cross Street, Melton Mowbray, Leicestershire. LE13 1NX.

Asfordby Branch Surgery, Regency Road, Asfordby, Leicestershire, LE14 3YL

The practice were a teaching practice for GP trainees.

Latham House Medical Practice was part of the Primary Care Research Network (NHS National Institute for Health Research).

Latham House Medical Practice had opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided to Northern Doctors.

An urgent care service provided patients with more choice and increased access to healthcare at weekends, bank holidays and evenings. Minor injuries and illnesses were treated locally and the service aimed to reduce the time it takes patients to be seen and treated. Patients could attend one of the centres at Melton Mowbray, Oakham, Oadby or Market Harborough.

In April 2015 we spoke with the management team with regard to their registration certificate. There had been changes to the GP partners which was not reflected on their current certificate and did not fulfil the criteria in the CQC (Registration) Regulations 2009. After that inspection we received information that the practice had commenced the process to update their registration certificate. At this recent inspection we spoke to the management team as the registration certificate was still not updated and further changes had been made to the GP Partners. The management team gave us assurance that they would ensure that they would complete the necessary forms to ensure that this is updated.

The practice did not have an updated statement of purpose available which is a requirement under regulation 12 of the CQC (Registration) Regulations 2009.

Why we carried out this inspection

On 16 April 2015 we had 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. That inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

At that inspection we found the practice Required Improvement overall but specifically the rating for providing a safe and well led service was Requires Improvement. Effective, Caring and Responsive was rated as good. As a result the practice was given requirement notices for Regulations 12, 13 and 18.

The purpose of this comprehensive inspection was to ensure that sufficient improvement had been made following the practice being given an overall rating of Requires Improvement as a result of the findings at our inspection on 16 April 2015. We also checked to see if had followed their action plan from the last inspection and to assess whether they now met their legal requirements.

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.

We carried out an announced visit on 7 December 2016.

During our visit we:

- Spoke with a range of staff.
- Observed how patients were being cared for.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

Detailed findings

- 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 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.

Inadequate

Are services safe?

Our findings

At our previous inspection on 16 April 2015 we rated the practice as requires improvement for providing safe services as the arrangements in respect of significant events, safeguarding, management of risk, cleanliness and infection control,were not adequate.

We found that some of these arrangements had deteriorated when we undertook a comprehensive inspection on 7 December 2016. The practice is now rated as inadequate for providing safe services

Safe track record and learning

The practice had a system in place but we found this most recent inspection it was not effective, consistent or clear in regard to significant events. Therefore we could not be assured that the practice could evidence a safe track record over the long term.

We found the new process for significant event analysis (SEA) put in place since the last inspection was not effective. We found that the documents were stored on the practice's internet and a spreadsheet had been put in place. However there was no detail of who had raised the significant event. Recording of the event, details of the investigation or what actions and learning had taken place were not clear.

33 significant events had been recorded since April 2016. We looked at five events and found that the recording and analysis of all five did not demonstrate a clear account of what had happened, was not in-depth and records of the actions taken were brief. For example, in regard to two week wait referral which the patient queried after four weeks. The referral had not been sent but the practice immediately rectified this error and ensured that the patient received an appointment within a week. No evidence of discussion, no learning and no evidence of review in meeting minutes we looked at. At the inspection the practice checked the patient records and they attended secondary care and been seen after the second referral. A second significant event we reviewed was a high blood result in relation to anti-coagulation medicines. Blood test had a high reading. We were unable to find any information in relation to the outcome of this event, when it had been discussed or what learning had been shared. After this inspection the practice revised it SEA policy, disseminated the new process to staff and discussed it at the practice learning team meeting on 14 December 2016. At this inspection we did not find any improvement in the notes of the discussion or improvements made as a result of significant events in for meeting minutes we reviewed.

During the December 2016 inspection, we requested details of annual reviews of significant events. We were told that these had not been carried out and that there had been no exercise undertaken to identify any themes or trends.

We found that the practice did not have an effective system in place for receiving, discussing and monitoring of patient safety alerts. On the day of the inspection the management team were unable to show us a system in place. It was not clear whether the practice had received all the patient safety alerts distributed by the various agencies. There was no log of alerts received and no evidence of how they had been shared and actioned. The practice was unable to evidence that all staff were aware of any relevant alerts to the practice and where they needed to take action. There was no system for the storing of patient safety alerts for future reference. The practice had a policy in place but it did not provide clear guidance for staff. After this inspection the practice revised the process and discussed with staff at the practice learning team meeting on 14 December 2016.

Overview of safety systems and processes

The practice had improved some of the systems, processes and practices in place to keep people safe but there were also areas identified where systems were still not well embedded.

- At the inspection in April 2015 we found that the practice did not have effective systems to manage and review risks to vulnerable children, young people and adults.The practice
- At the inspection in December 2016 we found that the practice had worked hard to implement systems and processes in regard to safeguarding. There was a lead GP for safeguarding.

  Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. The practice had undertaken audits of safeguarding referrals and where they had not received feedback they had contacted the relevant team to be updated. We found evidence that safeguarding alerts for children and vulnerable adults were recorded on the electronic

patient record. Policies were accessible to all staff but did not identify who the lead GP for safeguarding was. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.

- The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff we spoke with demonstrated they understood their responsibilities and had received training on safeguarding children and vulnerable adults relevant to their role. However the records we saw indicated that not all staff were up to date with safeguarding training although we were provided with evidence that some staff had completed outstanding training following our inspection.
- We contacted the East Leicestershire and Rutland Clinical Commissioning Group who kept records of GP Safeguarding and we were told that all the GPs were up to date with Safeguarding children level three but two GPs were out of date with Safeguarding Adults. Practice nurses had undertaken level 2 training.
- A notice in the waiting room advised patients that chaperones were available if required. (DBS
- At the inspection in April 2015 we found that some of the processes in place in regard to infection prevention and control were not effective. For example, infection control audits, (Control of substances hazardous to health) COSHH, cleaning schedules at the Asfordby Branch.
- At this inspection we observed Latham House Medical Practice had maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead. There was an infection control protocol in place and the majority of staff had received up to date training. We found that the maintenance manager supervised the cleaning team employed by the practice. Cleaning schedules were in place. We saw that spot checks of cleaning took place but the records were not detailed. Meetings took place but the meeting minutes we reviewed were not detailed and did not evidence what actions had been taken when areas for improvement were discussed. We looked at the training matrix and could not see where the staff who were employed by the practice as cleaners had received any mandatory training. We found two sharps bins which had not been assembled as per national guidance. We brought this to the attention of the management team who immediately rectified this problem.
- We found that the practice had carried out an infection control audit in November 2016. No action plan had been put in place or evidence that action was taken to address any improvements identified as a result.
- We reviewed COSHH safety data sheets at both the main practice and the branch surgery for products in use but there was no system to identify when these had last been reviewed. There were no risk assessments available which related to COSHH.
- We visited the branch surgery at Asfordby was clean and tidy and that there were now cleaning records available.
- Some of the arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).
- At this inspection we checked the system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. We found that the system was not effective and did not protect the health and safety of patients on these high risk medicines. For example, we reviewed five patient electronic records and found some patients had not received appropriate blood monitoring and no alert was in place to ensure prescribers had a full record of medicines a patient was being given. After the inspection we sent the practice a letter with a specific request for more detailed information in regard to the management of high risk medicines. The practice responded to the request about a number of medicines that were either considered high risk or were contraindicated in combination with other drugs to decide whether they were practicing safely. Since the inspection the practice had reviewed all the patient records and amended their systems to ensure blood monitoring is completed before medications are prescribed. They told us they had contacted all the

patients whose tests were outstanding and asked them to attend for a medication review. The practice also told us that since the inspection they had revised its High Risk Medicine Monitoring Policy.

- At the inspection in April 2015 we saw records of monthly partner meetings that noted the actions taken in response to a review of prescribing data. The information was disseminated to all partners but we did not see any evidence that the registrars within the practice received the same information to ensure they had taken the same action.At this inspection we reviewed one set of meeting minutes from March 2016 where registrars were in attendance and prescribing data had been discussed.
- Blank prescription pads were kept securely at the main practice but we found at the branch surgery that they were kept in an unlocked cupboard. There was no system to track the prescriptions through the practice and we were told that neither the printers which held the prescription forms nor were the consulting rooms locked at any time. Since the inspection the practice have informed us that prescription stationery is now kept locked at the branch surgery.
- Four of the nurses had qualified as an Independent Prescriber. They received regular peer reviews and support from the medical staff for this extended role
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- At the main practice we looked at records of refrigerator temperatures for the fridges in treatment rooms and saw that these had been checked daily. A cold chain policy was in place to provide guidance to staff in the event of a break in the cold chain.
- In April 2015 we visited the branch surgery at Asfordby and checked medicines stored in the treatment rooms and refrigerators. We looked at the checklist in place for checking and recording the daily temperatures of the refrigerator and found that records of temperatures had been kept but there was no indication that the temperature had been reset on a daily basis in line with requirements. At our most recent inspection we found that there was a column in the checklist to indicate whether the refrigerator had been reset but this was still not being recorded. Furthermore we spoke with the member of staff responsible for checking the temperatures who told us they did not reset the temperature as they were not aware it was a requirement.
- At the inspection in April 2015 we saw that the practice had a recruitment policy and procedure in place that set out the standards it followed when recruiting clinical and non-clinical staff. The policy had been reviewed in January 2015 but did not contain guidance for staff on the appropriate recruitment checks required prior to employment. We were told by the practice manager that the practice had a rolling programme to check the DBS of all staff but this was ongoing and not all staff had currently been checked.
- At this inspection we found that there was a comprehensive recruitment policy dated November 2016 which included reference to appropriate recruitment checks required prior to employment. The records provided by the practice identified that since November 2016 demonstrated that they now have a process for DBS checks in place.
- We reviewed ten staff recruitment files and found that some appropriate recruitment checks had been undertaken prior to employment such as proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However this was not consistent and information provided prior to our inspection identified gaps in these checks for a number of staff. The business manager told us they were in the process of reviewing all staff files to update them with the correct information and that going forward the recently implemented recruitment policy would be followed to ensure appropriate checks were undertaken. On the day of our inspection we were unable to see indemnity cover for all clinical staff. There was no system in place to check that staff had maintained their registration with the appropriate professional body. Since the inspection the practice had revised its policy for professional registration checks.

Inadequate

Are services safe?

Monitoring risks to patients

Risks to patients were not adequately assessed and well managed.

At our inspection in April 2015 we found that there were limited procedures in place for monitoring and managing risks to patient and staff safety.

At this most recent inspection we found there was a health and safety policy available with a poster in the reception area. There was also a health and safety policy available with a poster in the kitchen of the branch surgery.

At the inspection in April 2015 we found that the practice had carried out a fire risk assessment in April 2014 that included actions required to maintain fire safety. Actions were identified but we did not see an action plan, person responsible to deal with actions and a timeframe.

At this most recent inspection we found that the fire risk assessment for the main practice completed in March 2016 was not fit for purpose. They had not made a suitable and sufficient assessment of the risks to which relevant persons were exposed for the purpose of identifying the general fire precautions needed. The fire risk assessment had not been regularly updated or appropriate fire safety measures put in place. Fire alarm and emergency lighting testing took place but we found gaps in the recording when the person responsible was busy or took annual leave. A fire drill at the main practice on 27 May 2016 which identified a number of concerns. This had not been reviewed by management team. We were given the name of nine members of staff who had been identified as fire wardens but we were unable to verify if they had all received fire warden training. No further fire drills had taken place. As a result of this concern we referred the practice to the Leicestershire Fire and Rescue service who told us they would visit the practice in January 2017 and review the fire safety arrangements at both the main practice and the branch surgery. They told us they would provide a report to the practice and inform the Care Quality Commission after the visit.

At the branch surgery we found the practice did not have suitable arrangements in respect of fire safety in accordance with the Regulatory Reform (Fire Safety) Order 2005. A fire risk assessment had been undertaken in February 2015 which was not fit for purpose, there was no written fire policy available and although the fire extinguishers and other equipment had been serviced regularly there were no arrangements for regular checks of the firefighting equipment or alarm system. The last recorded fire drill was in 2014. There were named fire marshals but only one of them was regularly at the branch surgery and had not received relevant training for the role. The majority of staff had undertaken fire safety training in the last year.

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.

At the inspection in April 2015 we found that the practice did not have a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw that the practice had legionella risk assessments for both Latham House Medical Practice and the Asfordby branch which were completed by an external company in June 2014. Both risk assessments identified actions that the practice need to take. We did not see any action plans, responsible person identified and timeframe for these actions to take place. At the time of the inspection the practice did not have any evidence that they had carried out regular checks of the water supply to reduce the risk of infection to staff and patients as documented in the risk assessments.

At our latest inspection we found that there were still not suitable arrangements in place relating to the management of legionella at both the main practice and the branch surgery. There was no risk assessment available at the branch surgery and there were no records of water temperature monitoring at either site in order to mitigate the risk of legionella.

At the end of the inspection we were given three risk assessments in relation to oxygen storage, waste management and risk of injury and exposure to potential blood borne viruses. We inspected the branch surgery in the village hall at Asfordby. The practice had not carried out any risk assessments in relation to the branch surgery.

On the day of the inspection the practice were unable to show us the five year Electrical Installation Condition Reports (EICR) for the main practice or the branch surgery. External contractors were contacted and undertook surveys on both premises on 8 December 2016. Both surveys were positive with a recommendation to repeat in 2019.

Inadequate

Are services safe?

On the day of the inspection the practice were unable to show us gas safety certificates for the main practice or the branch surgery. External contractors were contacted and undertook surveys on both premises on 8 December 2016.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place 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. At the branch surgery there was a panic alarm to alert staff to an emergency.
- The records provided showed that not all staff had received annual basic life support training in the last twelve months. There were emergency medicines available at both the main practice and the branch surgery.
- The practice and branch surgery had a defibrillator with adult and paediatric defibrillator pads available on the premises. Oxygen cylinders with adult and children's masks were also in place.
- 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 disaster continuity and recovery plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. There was no reference in this to arrangements for the branch surgery in the event of such an incident. Since the inspection the practice had reviewed and put in place separate plans for the main practice and the branch surgery. However none of the risks were rated and mitigating actions recorded to reduce and manage the risk.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

We saw minutes of practice learning team meetings held since the April 2015 inspection where NICE guidance was discussed and implications for the practice's performance and patients were identified and required actions agreed. For example, epilepsy. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. We saw evidence that the practice also reviewed guidelines from the Leicester Medicines Steering Group (LSMG) at practice learning team meetings. For example, in June 2016 Asthma and COPD.

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 for 2015/16 were 99.9% of the total number of points available, with 10.1% exception reporting which was 0.1% above CCG average and 0.3% above national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

For example:

- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 92.7% which was 2.1% above the CCG average and 1.4% above the national average. Exception reporting was 5.3% which was 0.6% below CCG average and 0.2% below national average.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that includes an assessment of asthma was 70.1% which was 3.5% below the CCG average and 5.4% below the national average. Exception reporting was 13.3% which was 1.4% above the CCG average and 5.4% above national average.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 87.4% which was 4.6% above the CCG average and 4.5% above the national average. Exception reporting was 4.8% which was 0.7% below the CCG average and 0.9% below national average.
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional was 93.8% which was 6.1% above the CCG average and 4.2% the national average. Exception reporting was 11.5% which was 3.4% below the CCG average and the same as the national average.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 74.8% which was 5.7% below the CCG average and 9% below the national average. Exception reporting was 5.4% which was 2.6% below the CCG average and 1.4% below national average.

We looked at the process the practice had in place for the exception reporting of patients where the patient did not attend for a review, or where a medicine could not be prescribed due to a contraindication or side-effect. We spoke with the management team who advised us that they would review the process and put further steps in place to ensure patient safety as it did not always have GP agreement for the patient to be exception reported.

At the inspection we found the practice had systems and processes in place to evidence quality improvement including completed clinical audit cycles. We looked at three audits sent to us before the inspection and a further two audits were shown to us during the inspection. We

Good

Are services effective?

(for example, treatment is effective)

spoke with the management team who acknowledged that more work was required to evidence the improvement in patient outcomes and the shared learning with the practice team.

The Prescribing lead GP told us clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics in line with antibiotic stewardship and current guidance. The practice were able to demonstrate that their antibiotic prescribing had reduced in line with current guidance. At the feedback session the Prescribing lead acknowledged that further work was required in relation to clinical audits.

We also looked at the practice hypnotic prescribing. The practice had chosen a random 90 patients which was only 0.2% of the practice population. The results showed a reduction in prescribing from 97% to 73%.

The practice had made use of the gold standards framework for end of life care. It had 337 patients on a palliative care register. 100% had received an annual review. The practice had palliative care meetings. These were internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Multi-disciplinary palliative care meetings were held monthly. They were attended by a number of GP's, nurses (practice, community and specialist) social care and a representative from the practice management team.

Effective staffing

At the inspection in April 2015 we found that there was not a clear system in place to identify and monitor staff training. They told us they had identified this as an area for improvement and had plans to implement a training matrix which would clearly show which training had been completed and monitor when further training or refresher training was due. At this inspection we found that staff we spoke with were competent in their roles but there was still not an effective system to identify and monitor the training needs of all staff.

- We saw evidence of an induction programme for newly appointed staff. The contracts and performance manager told us they were reviewing the programme to ensure it incorporated mandatory training such as safeguarding, infection prevention and control, fire safety and health and safety.
- The practice could demonstrate how they ensured role-specific training and updating for nursing staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes.
- We were told that staff appraisals were not up to date although we saw that nurse appraisals were scheduled in the next two months. The contracts and performance manager showed us an appraisal system they had developed but this had not yet been implemented.
- We saw evidence that the nursing team had individual and team peer review meetings which took place on a six monthly basis.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. However we found there were some gaps in training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We saw evidence that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from

Good

Are services effective?

(for example, treatment is effective)

hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

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. We saw notes of a practice learning team meeting in May 2016 where staff who attended had been given an update on Mental Capacity Act and Deprivation of Liberty (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. Nursing staff had undertaken MCA training.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice's uptake for the cervical screening programme was 76.6%, which was comparable to the CCG average of 78% and the national average of 74%. After three do not attends the practice sent a letter from their GP followed by an appointment to sign a waiver if they wish to decline cytology screening. The practice carry out smear audits for each nurse every three months to ensure they continue to be competent to undertake the procedure.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. 83.2% of patients eligible had attended for bowel cancer screening which was above the CCG average of 64 % and national average of 60%.
- 83.5% of patients eligible had attended for breast cancer screening which was comparable to the CCG and national average of 82%.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 91% to 96% and five year olds from 89% to 96% against a CCG average of 95%.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms at the main practice to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- At the branch surgery we saw that curtains or screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff at the main practice knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. This was more difficult at the branch surgery at Asfordby as there was only one receptionist on duty.

31 comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with a member of the patient reference group (PRG). They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. They highlighted that staff responded compassionately when they needed help and provided support when required. Comment cards aligned with these views.

Results from the July 2016 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable or above average for its satisfaction scores on consultations with GPs but lower than average for nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 85%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patient feedback on the comment cards we received told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Results from the July 2016 national GP patient survey showed patients responded positively to most questions about their involvement in planning and making decisions about their care and treatment. Most results were in line with local and national averages. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 83% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 79% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 85%.

Good

Are services caring?

The practice website contained relevant and easily accessible information.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The July 2016 national GP patient survey information we reviewed showed patients comparable results for the emotional support provided by the practice.

For example:

- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 88% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 91%.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1018 patients as carers (2.86% of the practice list).Written information was available to direct carers to the various avenues of support available to them.

Requires improvement

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours on a Monday from 7.40am to 7.50am and 6.30pm to 6.40pm, Thursdays 6.30pm to 6.40pm.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Urgent Care service where same day appointments were available for children and those with serious medical conditions.
- The practice had a call monitoring system in place which enabled the management team to look at call and demand and manage staff and appointments accordingly.
- The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. The practice had some information leaflets translated into Polish.
- The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as most facilities were all on one level. We saw that the waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Hearing loop and information for partially sighted was available at reception.
- There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.
- The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient reference group (PRG), for example, the PRG had raised the fact that accessing the practices services on the telephone needed to improve. The practice had increased the number of staff who answered the telephone but also needed to increase the number of telephone lines to ensure patient calls could be answered quickly.

Access to the service

The Latham House Medical Practice was open from 8.30am to 6.30pm. A duty doctor was on site from 8am to 8.30am and 6pm to 6.30pm. Appointments were available at various times between: 8.30 am - 5.30 pm at the main site at Melton Mowbray and in the mornings at the Asfordby branch surgery. Extended hours appointments were also available on a Monday from 7.40am to 7.50am and 6.30pm to 6.40pm, Thursdays 6.30pm to 6.40pm.

The practice had a nurse led minor treatment unit (MTU) which was open from 8.30 am to 6.00 pm. This was a walk in Service for any minor injury sustained within 48 hours.

The practice had recently introduced urgent care appointments led by a GP and nurse team every morning which were for patients who wanted to be seen on the day. The practice continued to have nurse led Immediate Access Clinics in the afternoon which also provided access for patients who requested an urgent or 'same day' appointment.

Results from the July 2016 national GP patient survey showed that patient's satisfaction with how they could access care and treatment were below local and national averages.

- 67% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 56% of patients said they could get through easily to the practice by phone compared to the CCG average of 67% and the national average of 73%.

Since the inspection the practice have told us that the patient reference group (PRG) had also undertaken an annual survey. They had 484 (1.36% of patient population) responses. They told us the results from November 2016 were positive in regard to patients who responded who were satisfied with the practice's opening hours. The practice also told us they had shared the results and agreed priorities to work on for the following year.

Comments cards we reviewed told us that they were able to get on the day appointments when they needed them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- The practice complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. It had been reviewed prior to the inspection but did not contain details of who the designated responsible person was who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the patient leaflet.
- We looked at the system the practice had for complaints and found that it was not clear and consistent. We were unable to see if the practice had followed the process described in its complaints policy. Documents pertaining to complaints were not kept in one place and the practice were unable to to find all the documents we required. We were therefore unable to ascertain if these were satisfactorily handled, dealt with in a timely way or whether lessons were learnt from individual concerns and complaints. There was no analysis of trends or action taken as a result to improve the quality of care.
- At the inspection in April 2015 we saw that the practice held quarterly meetings where complaints had been discussed. We could not see any evidence that information and learning had been shared with all staff within the practice. At this inspection we did not see any evidence that information and learning had been shared with staff.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 16 April 2015 we rated the practice as requires improvement for providing well-led services as there were limited governance arrangements in place.

We found at the inspection on 7 December 2016 there were some areas where there had been improvement, areas which required further work and also some ongoing breaches of regulations, including those relating to safe care and treatment and good governance. Therefore the practice is now rated as inadequate for being well-led.

Vision and strategy

The practice had a mission statement which was detailed in the patient leaflet. The practice stated they were committed to helping patients maintain good health, and to care for them during ill health.

Governance arrangements

At our inspection in April 2015 we found there were limited governance arrangements in place to support the delivery of their strategy. There had been a lack of effective systems in place in order to monitor quality and make improvements, limited arrangements for identifying and managing risks and an unstructured approach to dealing with significant events.

At this inspection there had been improvements in some areas but deterioration in others. The practice did not have an overarching governance framework and systems in processes in place to support the delivery of their strategy.

We found:-

- Patients were at risk of harm because some of the systems had deteriorated since the last inspection. For example, significant events, safety alerts, infection control,legionella staff training and complaints.
- Risks to patients were not adequately assessed and well managed. At this inspection we found that the system and processes in place in regard to fire safety had deteriorated. The fire safety risk assessment was not effective, fire safety and emergency lighting checks had gaps in monitoring, no evidence of fire warden training and the fire drill carried out in May 2016, where issues were found, they had not been discussed or actions put in place to prevent further occurrences.
- At the inspection in April 2015 we identified that CQC registration was not up to date and asked the practice to ensure that this was updated. At this inspection we found that this had still not been fully completed. However since the inspection the practice had commenced the process to add partners to the registration certificate.
- The Statement of Purpose was not up to date as there had been a number of changes to GP partners.

Leadership and culture

During the course of our inspection in April 2015 we found there were a lack of experienced leadership and a lack of clarity and some confusion as to who held responsibility in some areas.

- Since then the leadership in the practice had undergone further changes and at this inspection we still found that overall leadership was not effective. Although the practice was positive about future plans, we found a lack of accountable leadership and governance relating to the overall management of the service. The practice was unable to demonstrate strong leadership in respect of safety. For example, a number of issues which had been identified by us in April 2015 had not been addressed or or adequately managed which threatened the delivery of safe and effective care. We were told that since the last inspection the practice had gone through a management restructure with changes at senior management level. In some areas we looked at it was still not clear who took overall responsibility or who had the authority to make decisions. For example, day to day management of the practice, risk management and complaints. Since our inspection the practice had put plans in place for further improvement and had put in place an action plan to address this as part of their strategy going forward. These actions have not had time to be implemented or embedded but demonstrated that the practice had awareness of the need for change.

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.

Are services well-led?

Inadequate

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

Latham House Medical Practice had an active PRG which included representatives from various population groups. For example, a representative Age UK and a patient who represented the Polish Community

We spoke with the chairperson of the PRG and they were very positive about the role they played and told us they felt engaged with the practice. (A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice and PRG websites.

The practice had also gathered feedback from staff generally through staff meetings and informal discussions.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had recently piloted urgent care service appointments each weekday morning. The practice had reviewed the system to look at demand. Peer support took place for both GPs and nurses. At the inspection the management team told us this had worked well and were now planning to run the service all day. Feedback we looked at from patients was extremely positive.

The practice had commenced practice learning afternoons once a quarter where the practice was closed and all staff could attend for training and updates.

In January 2017 the practice planned to introduce a management system called Intradoc which would enable them to have a central area where all documentation could be kept and accessed by key staff.

On the day of the inspection they had two GP trainees. GP Trainees are qualified medical practitioners who receive specialist training in General Practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **The registered person had not provided the Commission with an updated statement of purpose containing information listed in Schedule 3.** **This was in breach of Regulation 12 of the Care Quality Commission (Registration) Regulations 2009.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users.** **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had failed to ensure that systems and processes were established and operated effectively.** **The provider had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of service users and others.** **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**