

Mrs Saeeda Parwaiz

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?

Requires improvement



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 Ratby Surgery on 12 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, well-led, effective, caring and responsive services. It was also good for providing services for older people; patients with long term conditions; families children and young people; working age people and those recently retired; people experiencing poor mental health and people whose circumstances may make them vulnerable. We found the practice to be requiring improvement in safe.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Information about services and how to complain was available and easy to understand.

Summary of findings

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

Importantly the provider must;

- Ensure that the recruitment policy is followed in all and that appropriate recruitment checks For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).
- Ensure that all staff receive an annual appraisal and that it is recorded.

- Ensure that a policy for the management, testing and investigation of legionella is implemented or that a risk assessment has taken place.

Importantly the provider should;

- All procedures and policies to be reviewed to ensure their relevance and current best practice.
- Ensure that clinical audits include a second cycle to complete the process.

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 requires improvement for providing safe services as there are areas where it should make improvements.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Medicines were managed safely and effectively. Appropriate recruitment checks were not in place and we were unable to find evidence of reference and qualifications.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or below average for the locality but above national average in some cases. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Good



Summary of findings

appointments available the same day. 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 that the practice responded quickly to issues raised with learning from complaints shared with staff and other stakeholders.

Are services well-led?

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

It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Policies and procedures required review to ensure that they were relevant and practice specific. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had a patient participation group (PPG) that was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Good



People with long term conditions

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice also linked with the CCG for specialist nurses to work in practice to assist in the management of patients, for example, diabetes and COPD. Longer appointments and home visits were available when needed. As the practice was single handed, all the patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as requires improvement 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 who were at risk, for example, children and young people who had a high number of A&E attendances where brought to the attention of the GP. Immunisation rates were below average for some of the standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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).

Good



Summary of findings

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 website signposted patients to other healthcare services as well as a full range of health promotion and screening that reflects the needs for this age group. For example the practice had exceeded the target figure of 80% of women eligible for a cervical smear test.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable including homeless people, travellers and those with a learning disability.

The practice had carried out annual health checks for people with a learning disability and all of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice had 113 travellers on its practice list as permanent patients, which is four percent of the list size. The practice worked well with and had good liaison with a nurse employed by the clinical commissioning group who dealt specifically with patients in this group.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

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

100% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Due to the workload pressures at the practice and being a single handed GP the practice recognised that they can improve on the diagnosis and screening rates for dementia and this will be something that will be looked at with the new partner starting.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. Staff had received training on how to care for people with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

We spoke with one patient during our visit. We reviewed 23 comments cards that had been provided by CQC on which patients could record their views and they were positive about the service experienced. Patients said they were able to get an appointment with the GP within a day or two, had friendly reception staff, caring GP, quick and efficient, good standard of care, appointments usually available same day and they felt the practice offered a very good service.

Patients said that the practice was clean and staff practiced good hygiene techniques.

We looked at the results of the Royal College of GP survey completed in October 2014. 40 forms had been distributed to patients. All had been returned and

completed. We reviewed the reflective template that had been completed as a result of the exercise. In this the issues raised had been acknowledged and the GP had put forward solutions to them. The GP had recognised that part of the problem was that there was only one GP for a GP partner.

We also looked at the results of the GP Patient Survey from January 2015.

We saw the results of the Friends and Family Test for the months of January to April which showed that out of 81 that had been completed 88% said they were either extremely likely or likely to recommend the practice to friends or family.

Areas for improvement

Action the service **MUST** take to improve

- Ensure that the recruitment policy is followed in all and that appropriate recruitment checks For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).
- Ensure that all staff receive an annual appraisal and that it is recorded

- Ensure that a policy for the management, testing and investigation of legionella is implemented or that a risk assessment has taken place.

Action the service **SHOULD** take to improve

- All procedures and policies to be reviewed to ensure their relevance and current best practice.
- Ensure that clinical audits include a second cycle to complete the process.

Mrs Saeeda Parwaiz

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included an additional CQC inspector, a GP, and a practice manager.

Background to Mrs Saeeda Parwaiz

Ratby Surgery, is located in Ratby a commuter village and civil parish in the Hinckley and Bosworth district of Leicestershire, England. It has a population of about 4,000. The practice provides GP services under a (GMS) General Medical Services contract to 2800 patients. The practice was established in 1986 by Dr Parwaiz.

The patient population has a relatively low deprivation score of 11.5 compared with a national average of 23.6, although within the practice population there was some evidence of deprivation. Both male and female life expectancy are slightly above the national average. The age distribution of the practice has a higher percentage of people between the ages of 40 and 49 against that of the national profile.

The practice has a single partner GP, one practice nurse, a practice manager and a strategy manager (managing partner) alongside three reception staff and a cleaner who is directly employed by the practice. Locum GPs are used to support the partner GP. The practice had successfully recruited a new partner to join the practice in the coming months.

The practice is located over two floors, though all areas accessed by patients were located on the ground floor.

The surgery is open from 8.00 am until 6.00 pm Monday to Friday, with GP consultations available from 9 am to 11am and 3.00 pm until 5.30 pm. On Thursday the surgery closed at 1.00pm and GP appointments were available from 9.00am to 1.00pm. The practice provides evening appointments by prior arrangement on a Monday evening until 8pm.

The practice lies within the NHS West Leicestershire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

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

The practice was previously inspected by the Care Quality Commission on 6 February 2014. This was using our previous methodology and consequently was not rated. At that inspection it was found to be compliant in all areas inspected.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 May 2015 and a CQC inspector re-visited on the 19 May 2015 to speak with staff who had not been available at our initial visit. During our inspection we spoke with a range of staff and spoke with one patient who used the service. We reviewed 23 comment cards and letters where patients and members of the public shared their views and experiences of the service.

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

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed.

This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of the five significant events that had occurred and we were able to review these. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including receptionists and administrators, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. We saw that learning had been identified and action was taken where necessary. For example, a 'flag' was placed on patient computer records where patients had similar or the same names for staff to be extra vigilant.

National patient safety alerts were disseminated by the practice or strategy manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, an example being the outbreak of the Ebola virus in West Africa.

Reliable safety systems and processes including safeguarding

GPs used the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

The practice had systems to manage and review risks to children and vulnerable adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies.

The GP was the practice lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role and we saw evidence of this. All staff we spoke with were aware who the lead was if they had a safeguarding concern. Informal meetings were held with all staff daily to discuss any concerns. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Information on safeguarding vulnerable adults and children was displayed in the patient waiting area.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. A formal chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent to the procedure. Family members or friend may be present but they cannot act as a formal chaperone. Staff told us that chaperone duties were carried out by the receptionists. We spoke with the reception staff who explained and understood their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination. There was no DBS for this staff member however a risk assessment had been carried out. In addition we were assured that chaperones would not be in a position where they would be left alone with patients during chaperoning duties.

Screen alerts on the practice's electronic records were utilised to make staff aware of any relevant issues when patients attended appointments; for example people with the same or very similar names and those that may have demonstrated aggression.

The practice actively monitored vulnerable patients, such as those with learning disability and the frail elderly and

Are services safe?

was signed up to the enhanced service to help reduce the number of unplanned emergency admissions to secondary care. Staff told us that there were four patients that had severe learning disabilities and these patients were given an annual health check in their own home so as not to upset their routines. The practice had a child emotional support pack. This contained a list of up to date contacts for various crisis interventions. The GP would often see children and parents in the early evening to discuss issues to allow more time and less pressure. Appropriate information was given to the parent which was supportive and also helped to manage problems in a preventative rather than reactive way. The practice had a good relationship with other healthcare professionals. For example, a patient that was a high A&E attender via 999 was discussed at a joint meeting held with the Ambulance service and the Proactive Care Nurse. A Proactive Care Nurse is a nurse employed by the CCG that works across a number of practices. This nurse provides care to selected people at home that require nursing care but do not need to be in hospital. This helps to prevent unnecessary hospital admissions. Discussions around support for the patient resulted in reduced calls to 999 as the anxiety was managed by the nurse alongside the GP.

Medicines management

There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Antibiotic advice was in a written format to inform locum GPs and help reduce community acquired infections and bacterial resistance. The formulary was regularly updated and available to locums. We saw that the GP attended meetings with the CCG to discuss prescribing policy and guidance.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that the nurse had received appropriate training to administer vaccines.

The practice had a medicines management policy which included details of drugs held for use in a medical emergency.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not used.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw cleaning schedules were in place that detailed the cleaning to be completed. We saw that the cleaner confirmed the schedule had been adhered to on a weekly basis. There was a yearly review of the cleaning specification to reflect any changes necessary. Patients we spoke with and comments cards we received said they always found the practice clean and had no concerns about cleanliness or infection control.

The practice manager was the lead for infection control within the practice and had undertaken further training for this. They were able to explain the protocol for infection control and were responsible for the practice infection control policy which had been reviewed in 2014. All staff received training during their induction about infection control specific to their role and received regular updates through on-line learning resources. We saw evidence that infection prevention and control audits had been carried out last year and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. We spoke with a member of the nursing staff who was able to describe how they would use these to comply with the practice's infection control policy. We spoke about the management of spillages (body fluids) and we checked the spillage kits. There was also a policy for needle stick injury.

The practice used disposable single use instruments and had done for the last five years for performing cervical smears.

The practice did not have a policy nor had they undertaken a risk assessment for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment by an outside contractor.

Staffing and recruitment

Records we looked at did not contain evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. For example we saw that one nurse had been employed since February 2015. There was no evidence of any references, proof of identity, DBS check or registration with the Nursing and Midwifery Council. Another nurse employed by the practice only had details of their DBS. No other details of this nurse were available. Following the initial inspection further recruitment and training was evidenced for one of the nurses including training and DBS however appropriate recruitment checks were not in place for all employed staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Records demonstrated that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

to the practice. These included annual checks of the building, the environment, medicines management, dealing with emergencies and equipment. The practice also had a health and safety policy.

The practice had in place a process to respond to risk, by means of being flexible in their approach. The GP was on site and always available to see patients at short notice. For example, end of life patients were given "open access" to the GP which meant that the staff and patient were aware that if the patient needs the GP then the GP would contact them as soon as possible.

We spoke with staff who explained that if there was a need to see patients there was always the option to add patients to be seen after the normal surgery had finished as the GP was in the practice until 8pm daily.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. There was an Emergency Procedure Handbook accessible to all staff kept with the equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Hypoglycaemia is a low blood sugar. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness, access to the building and the incapacitation or death of the GP. The document also contained relevant contact details for staff to refer to.

Are services safe?

The practice had carried out a fire risk assessment on 1 March 2015. Records showed that staff were up to date with fire training and that they practised regular fire drills last one being February 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GP that they completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the nurse supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The GP had already highlighted issues that would be focussed on with the new partner in place.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

Discrimination was avoided when making care and treatment decisions. Interviews with staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding end of life and advanced care planning which demonstrated good results. We also saw a further audit that linked to the medicine reconciliation project to identify patients' accurate current medication compared with that

on GP record. We saw evidence of an audit following identification of higher than CCG average in orthopaedic referrals in 2014 and that out of 26 referrals only one was considered inappropriate.

We noted that none of the audits had been subject to a full cycle with a second audit to test the effectiveness or otherwise of the action identified in the original process.

We looked at the QOF data for the year 2013/14 which was the last year for which complete data was available. We saw that in this year the practice achievement was below both CCG and national averages in most areas. For example for 2013/14 the total QOF achievement was 3.2 percentage points below the CCG average and 0.1 percentage point above the national average. In specific areas such as asthma, dementia, depression and diabetes it was below CCG and National average, with epilepsy 29.3 percentage points below CCG average and 19.4 percentage points below National.

The GP was aware of the low performance in these areas and had successfully recruited a new partner who would be able to assist in these areas. The practice had also experienced difficulties recruiting nursing staff that would normally be key to these areas and had enlisted the help of the CCG who had provided some chronic disease nurses.

The practice was working towards using the gold standards framework for end of life care. The practice held palliative care multi-disciplinary team meetings every quarter and the GP, Nurse, Proactive Care Nurse, Practice Manager, Strategy Manager and District Nurses could all be in attendance. Future plans were to include the Long Term Conditions Nurses. We saw minutes relating to these which evidenced planned actions.

Effective staffing

Practice staffing included nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. The GP had been re-validated (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Are services effective?

(for example, treatment is effective)

We saw that some staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

The nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties, for example the administration of vaccines and cervical cytology. They had an extended role and saw patients with long-term conditions such as asthma and diabetes. The practice was able to demonstrate that the nurse had appropriate training to fulfil all these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 111 service both electronically and by post. The GP, or locum GP in her absence saw these documents and results and was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had engaged with the services of the CCG to provide nursing staff with specialist skills in diabetes and chronic obstructive pulmonary disease (COPD).

The GP understood the isolation of single handed general practice and had good support from the other clinicians in the locality.

The practice was commissioned for the enhanced service to reduce emergency admissions to secondary care. The practice had identified the top 2% of most vulnerable patients falling into this category and had care plans in place. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. These were attended by GP, strategy manager, practice manager and also LOROS Nurse (LOROS is a local charity that provides specialist palliative care to the population of Leicester, Leicestershire and Rutland who are 18 and over with a terminal illness),

Proactive Care nurse and District Nurse. These meetings were every two to three months. We saw minutes from these meetings that were well documented with planned actions to complete which showed that patients where unplanned hospital admissions were anticipated were discussed.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. 100% of care plans had been reviewed in last year in relation to patients with a learning disability whilst 71% of patients with dementia had been reviewed. An example of this review was seen that showed physical and medical review. All clinical staff demonstrated a clear

Are services effective?

(for example, treatment is effective)

understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. Patients 'verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP personally summarised all new patients and reviewed their existing medication. We noted a culture among the GP and practice staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic flu vaccines, health checks or screening programmes that patients were eligible for.

The GP and practice looked to educate patients in all aspects of their health care and had different topics displayed in the practice. We saw an area in the waiting

room that was currently showing alternatives to Accident and Emergency attendance. There was also a display for avoidance of antibiotics in viral illness which the GP felt was very important.

A new pharmacy first system set up by the CCG was being promoted to avoid use of GP time for conditions that could be managed by a pharmacist and we saw a large stand with leaflets to demonstrate this service.

The practice's performance for cervical smear uptake was 82.75%, which was in line with the national average. There was a policy to offer reminders for patients who did not attend for cervical smears. There was a mechanism of following up patients who did not attend which was also used for other national screening programmes. Flags were put on the front screen of the patient record so that if a patient attended or telephoned, the reception staff would quickly identify any outstanding reminders and encourage attendance.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the results of the National Patient Survey for 2014 and found that; 92% of respondents said it was easy to get through to this surgery by phone (CCG average 73%); 76% of respondents with a preferred GP usually got to see or speak to that GP (CCG average: 57%) and 88% of respondents usually waited 15 minutes or less after their appointment time to be seen (CCG average 71%).

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and letters, and without exception they were positive about the service experienced. Patients said they were able to get an appointment with the GP within a day or two. They said that the practice was clean and hygienic and that reception staff were friendly and that the GP was quick and efficient and delivered a good standard of care with appointments usually available same day. They felt the practice offered a very good service. They said staff treated them with dignity and respect. We also spoke with one patient on the day of our inspection.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information remained so. The patient reception and waiting area was spacious which enabled patients who may have been queuing to speak with a receptionist to stand away from the reception area to help avoid overhearing conversations. There was a notice that informed patients that a private area was available for conversations should they require it.

We saw evidence that confidential paper waste was collected and destroyed by an external contractor. Patient records held in paper format were stored securely and records held on computer were could only be accessed by the appropriate staff using their computer 'smart card'

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the GP.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas.

The patient we spoke with and feedback on the comments cards informed us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. However staff told us the practice currently did not have any patients that did not speak English.

Care plans were in place for some older people and all had been reviewed in agreement and with involvement of the patient.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patient we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

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

The patient waiting area had notices that directed patients to information on bereavement and support for carers.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice told us that they engaged regularly with the Clinical Commissioning Group and other practices to discuss local needs and service improvements.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services for example those of travellers. The practice demonstrated a clear and unambiguous approach to equality and diversity. They had also undertaken formal training in Equality and Diversity for the practice staff.

The premises and services had been adapted to meet the needs of patient with disabilities although the main door to the practice was not automatic. The reception staff were situated near to the door and would be able to assist any patients if required. The practice was situated on the ground and first floors of the building with all services for patients on the first floor. We saw that the waiting area was 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.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. There was also the facility to make appointments on-line.

Appointments with the GP were available from 9 am to 11am and 3.00 pm until 5.30 pm. On Thursday the surgery

closed at 1.00pm and GP appointments were available from 9.00am to 1.00pm. The practice provided evening appointments by prior arrangement on a Monday evening until 8pm.

The practice's extended opening hours on one evening a week was particularly useful to patients with work commitments.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to

Longer appointments were also available for patients who needed them, for example those with long-term conditions. The practice ensured that people that needed to see different health professionals, such as the midwife and the GP had the appointments made concurrently to save the patient having to come back another day. The practice also ensured that patients that had more than one long term condition were given appropriate time to cover all in the one appointment, up to 45 minutes per appointment depending on the number of conditions. This also included appointments with the GP or nurse. Home visits were made to local care homes when requested by the care home following triage by the GP. When the care home staff telephoned they were given a time to call back to speak with the GP who then either gave advice or arranged to call the same day.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The GP was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system and posters were displayed in the patient waiting area. Further information was available in the practice with an easy to read flowchart and on the practice website.

We looked at four written complaints received in the last 12 months and found they had been handled and dealt with appropriately with an apology sent were appropriate.

We saw that learning and matters arising from the complaints had been communicated to staff at a meeting.

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 to deliver high quality care and promote good outcomes for patients and these were shared and understood by staff.

All the members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the shared drive on any computer within the practice. We looked at 13 policies and procedures and ten of these had not been reviewed for three years. The policies were also available to staff in hard copy in a folder that was clear easy to navigate and held in reception for staff to refer too.

There was a clear leadership structure with named members of staff in lead roles. For example, there was the practice manager that was the lead for infection control and the GP was the lead for safeguarding. Staff members we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed its performance was below CCG and national standards in most areas. The practice had achieved 93.6% of QOF for the year 2013/14 the CCG average for this was 96.8%. The GP told us that due to shortage in staff QOF had slipped in some areas and that they had concentrated on patient care and that recruitment of a new partner would assist in improving the areas that had already been identified, such as dementia.

The GP told us that there was a good peer review system which they took part in with neighbouring GP practices. This process gave the practice the opportunity to measure its service against others and identify areas for improvement.

The practice had carried out various clinical audits which it used to monitor quality and systems to identify where action should be taken. However, we noted that these were not completed audit cycles and had not been subjected to further audit and evaluation to measure their effectiveness.

The practice had arrangements for identifying, recording and managing risks. We saw the risk assessment action plan from February 2015 which looked at physical and environmental risks, for example, we saw risk had been identified of the steep stairs.

The practice held regular daily meetings at which performance, quality and risks had been discussed. Staff we spoke with confirmed that these informal meetings took place daily but they were not recorded. The GP told us they were to be made more formal and recorded in the future.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The Practice Manager and Strategy Manager were responsible for human resource policies and procedures. We reviewed a number of policies, including disciplinary procedures, induction policy, whistleblowing and public liability which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. However the policies that we looked at had not been reviewed since 2012.

Seeking and acting on feedback from patients, public and staff

The practice had a patient participation group. The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. Unfortunately none of the members were available to speak with us on the day of our inspection. The group had seven active members.. We saw that the PPG had a prominent presence on the practice website and had its own noticeboard in the patient waiting area at the surgery. We saw that the group had carried out surveys of patients to gauge patient views on access to the service and getting repeat prescriptions.

Are services well-led?

Good 

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

The practice had gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Meetings that had been held were not recorded.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

The nurse we spoke with told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that there was evidence that regular formal appraisals had taken place for two of them; the other two were new to post. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings ensure the practice improved outcomes for patients.

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	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not undertake adequate and appropriate recruitment checks prior to employment.
Maternity and midwifery services	
Treatment of disease, disorder or injury	