Dr Kevin Newley

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Maples Surgery offers a range of primary medical services from a single surgery at 71 Evington Road, Leicester LE2 1QH

Prior to our inspection we consulted with the clinical commissioning group (CCG) and the NHS England Area Team about the practice. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

We looked at patient care across the following population groups: Older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health.

We carried out an announced comprehensive inspection on 8 January 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 all of the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered having regard to best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment with the GP 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.
- Patients experienced exemplary customer services from reception staff.

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

The provider should:

- Ensure that recommendations contained within the practice legionella assessment are carried out.
- Ensure that clinical audit cycles are completed.
- Adopt a system to ensure the integrity of pathological samples and to protect staff from the risk of infection associated with handling samples.
- Ensure that fridge temperatures are checked and recorded in line with best practice guidance.

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?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from NICE and took it into account when delivering care and treatment. People's 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 have been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS 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 the GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

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. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

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

Good

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.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All 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.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

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

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had offered annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health were offered 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. It carried out advance care planning for patients with dementia.

Summary of findings

What people who use the service say

During the inspection we spoke with patients and carers that used the practice and met with members of the patient participation group (PPG). A 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.

We also reviewed 38 comments cards that had been provided by CQC on which patients could record their views.

All the patients we talked with, and the patients who had completed comments cards, emphasised the caring attitude of the staff and the quality and efficacy of the treatment and care they received.

They told us that the care and treatment they received was good and that they felt fully informed as to their treatment options. Their confidentiality and dignity was respected.

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

They stated that getting an appointment was simple and consultations were always available within a few days and on the day if medically necessary. They told us that the practice staff accepted patients opinions if they stated they wanted a same day appointment. Patients said they were seen on time.

Areas for improvement

Action the service SHOULD take to improve
Action the provider should take to improve

- Ensure that recommendations contained within the practice legionella assessment are carried out.
- Ensure that clinical audit cycles are completed.
- Adopt a system to ensure the integrity of pathological samples and to protect staff from the risk of infection associated with handling samples.
- Ensure that fridge temperatures are checked and recorded in line with best practice guidance.

Dr Kevin Newley

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP and also included a GP practice nurse and an additional CQC inspector.

Background to Dr Kevin Newley

The Maples Surgery is located close to the centre of Leicester and consists of a single location.

The practice population consists of a rich and diverse mix of ethnicity, culture and religion beliefs, including a significant number of patients originating from eastern Europe.

On the day of our inspection the patient list was 2,777.

It is located within the area covered by Leicester City Clinical Commissioning Group. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

The practice is staffed by one GP. The practice employs one advanced nurse practitioner with prescribing privileges and one healthcare assistant. They are supported by a practice manager and a receptionist.

The surgery was open from 8 am until 6.30 pm daily with extended opening hours on one evening until 7.30 pm and one morning from 7 am.

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 is located in a large town house which has been converted and improved to meet the needs of patients.

The practice was last inspected by the Care Quality Commission in June 2014, when it was found to be complying with the Health and Social Care Act 2008.

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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:

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 are provided for specific groups of people and what good care looks like for them. These 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.

We carried out an announced visit on 8 January 2015. During our visit we spoke with the GP, nurse, the practice manager and receptionist. We spoke with patients who used the service. We observed the interactions between patients and staff, and talked with carers and family members. We met with representatives of the patient participation group (PPG). 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.

We reviewed 38 CQC comment cards where patients had shared their views and experiences of the service.

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

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. 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 two significant events that had occurred during the last year and we were able to review these. We saw that they had been dealt with correctly and in a timely manner. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff we spoke with knew how to raise an issue for consideration at practice meetings and they felt encouraged to do so. Significant events was a standing item on the monthly practice meeting agenda.

National patient safety alerts were disseminated by the practice manager to all staff who signed to say they had read them. Staff we spoke with were able to give examples of a recent alerts regarding Ebola.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The GP was the lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and were confident they could to speak to them if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or on the 'at risk' register.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. There were clear signs in reception and clinical rooms with regard to chaperoning if requested. Patients were aware that the only GP was male and are asked if they require a chaperone as they book their appointment. All nursing staff, including health care assistants, had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Refrigerator temperatures were checked twice daily and records we reviewed showed that the refrigerator had operated within the required temperature range. We did note however that the nurse recording this information had not noted the time the temperature was observed or signed the log to say that the temperature had been read, recorded and reset.

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.

Good

Are services safe?

Staff who received deliveries of medicines were clear in their responsibilities in maintaining the cold chain to help ensure their efficacy.

The nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse had received appropriate training to administer vaccines. The nurse was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

The practice had 21 young adult patients who resided in care homes who experienced mental health issues. We saw that their medication was reviewed every two months.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Expenditure on high risk medicines was low.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice did not hold any supplies of controlled drugs.

The Maples Surgery was not a dispensing practice.

Cleanliness and infection control

The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an infection prevention and control audit and issues identified had been addressed.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

Each of the three clinical rooms had hand washing sinks along with liquid soap, hand towels in dispensers and alcohol gel.

There was a spillage kit to be used to deal with blood spillage and staff were aware of its location.

We observed the premises to be very clean and tidy. There was no evidence of accumulated dust and the premises were free of clutter. Treatment rooms were fitted with easy clean floor coverings and the only carpeted area was the porch and two non- slip mats in reception. All were clean and free of staining and marks.

We saw there were cleaning schedules in place and cleaning records were kept. Each consulting room had a deep clean every week. We saw evidence that the cleaner met with the practice nurse and the other members of the team every two months to discuss cleanliness and to highlight any areas of concern or needing special attention. Any immediate day to day concerns were addressed as required.

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Disposable curtains were in place in treatment rooms that were replaced every six months and spare curtains were available in the event of soiling.

Pathology samples were handed in to reception and either put in a sealed bag for pathology or given to the nurse. There was a box for pathology but if the samples for the nurse had to wait they were left on the desk. We noted that reception staff did not wear gloves when handling samples that were not in sealed bags.

The practice had a policy for the management, testing and investigation of legionella (a water borne bacteria found in the environment which can contaminate water systems in buildings) and we viewed the assessment of risk that had been completed by an outside contractor. Although the surgery had been rated as low risk, the recommendations within the report had not been completed.

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.

Staffing and recruitment

All of the staff that worked at The Maples had done so for ten years or more. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. We saw evidence that checks were made to ensure clinical staff were registered with their appropriate professional body. All staff had undergone criminal records checks through the Disclosure and Barring Service (DBS), formally Criminal Records Bureau checks. The practice had a recruitment policy that set out the standards it would follow when recruiting clinical and non-clinical staff.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The total number of staff working at the practice was six, which included the cleaner. We were aware that the practice was attempting to recruit a part time salaried GP, a receptionist and a health care assistant. When the GP was unavailable, cover was provided by a locum GP who had worked at the surgery for some years. In addition an agreement was in place with a nearby medical centre that they would provide GP cover at short notice.

Patients were made aware that the practice GP was male upon them enquiring about joining the patient list. They were given the names other practices in the locality who had female GPs, should that be an issue. We were told that a patient had elected to go elsewhere on these grounds on one occasion only.

Staff told us there were always enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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 monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was available to all staff on the practice computer system.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed within team meetings, where health and safety was a standing agenda item.

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 and cardiopulmonary resuscitation. 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. The oxygen was stored in the nurse's treatment room. We observed that the door did not display a sign to indicate that oxygen was stored within the room.

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(a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar.) Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned absence of key staff and access to the building. The document also contained relevant contact details for staff to refer to and which local GP practices would accommodate patients from The Maples in the event that the service ceased to operate.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and could access guidelines from the National Institute for Health and Care Excellence and from local commissioners and took those into consideration. We also saw that the GP had access to other guidance such as the British Thoracic Society asthma guidelines and used this when treating patients. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GP that staff completed thorough assessments of patients' needs taking into account NICE guidelines, and these were reviewed when appropriate.

The GP led in specialist clinical areas such as diabetes and the practice nurse and healthcare assistant supported this work. The practice nurse was the lead in anti-coagulant testing and dosing, overseen by the GP. She was also the lead in asthma care and had undertaken specials training specific to that role. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We viewed data from the local CCG of the practice's performance for the prescribing of cephalosporin and quinolone antibiotics, which was high when compared to similar practices. The GP told us he made sure that he prescribed the most appropriate anti-biotics for a given condition, for example in treating urinary tract infections, where the CCG preferred antibiotic was shown to have high resistance rates. We saw that the GP had responded to feedback and that prescribing rates for cephalosporin and quinolone items had reduced. The GP told us that he tried to avoid prescribing antibiotics for young children unless there were clear indications.

The data also showed that the practice had a low rate of prescribing of non-steroidal anti-inflammatory drugs (NSAID) compared to similar practices. The GP explained that he exercises caution due to the concern of them being associated with heart attack. He based his practice on his experience of being a GP with a special interest in orthopaedic medicine.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We viewed minutes of the practice meetings where the subject had been discussed and staff updated on the progress of completing the plans.

Data showed that the practice had low referral rates to out-patient services. The GP told us that this was due to the good management of conditions within the practice setting and partly attributable to low disease prevalence.

Unplanned admissions to hospitals was low, being the third lowest of the 21 practices in the CCG cluster.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us one clinical audit that had been undertaken. This concerned the switching patients to alternative drugs and detailed the outcomes for patients. The GP told us that he reviewed the data provided by the CCG and reflected on those situations where the practice was an outlier of prescribing data. No other completed cycles of clinical audit could be produced.

The practice also used the information collected for the Quality and outcomes framework (QOF) and performance against national screening programmes to monitor outcomes for patients. For example, the practice had achieved above the CCG average in cervical screening. This practice was not an outlier for any QOF (or other national) clinical targets.

The team made use of audit tools, supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being considered. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GP had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GP had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or better to other services in the area.

Effective staffing

Practice staffing consisted of a GP, an advanced nurse practitioner with prescribing privileges, a healthcare assistant, receptionist, practice manager and cleaner. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted that the GP had an additional diploma in orthopaedic medicine, and the nurse had diplomas in health visiting and asthma care. The GP was up to date with their yearly continuing professional development requirements and was due for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

The advanced nurse practitioner was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. She had an extended role and saw patients with long-term conditions such as asthma and diabetes. She was also to demonstrate that they she appropriate training to fulfil these roles.

We saw evidence that all staff undertook 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.

Working with colleagues and other services

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

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by representatives from LOROS, the local hospice, but not by the district nurses although they were invited.

Collaborative working was undertaken with other healthcare providers and the practice held an antenatal clinic once a week, staffed by community midwives. The health visitor also held a monthly clinic at the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, special patient notes were sent to the local GP out-of-hours provider by facsimile to enable patient data to be shared in a secure and timely manner. None had been sent recently as the practice had no seriously unwell or terminally ill patients.

Electronic systems were also in place for making referrals, and the practice made referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS Web to coordinate, document and manage

Are services effective?

(for example, treatment is effective)

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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant to all new patients registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GP and nurse to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice also offered NHS Health Checks to all its patients aged 40-74.

The practice had identified the top 2% of patients who were most likely to require admission to secondary care and was developing personal care plans for each patient. We saw that the matter was discussed at practice meetings and all members of staff were involved. Specific appointments had been allocated to enable the identified patients to formulate and agree their care plan with a clinician.

The practice had numerous ways of identifying patients who needed additional support, and was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they offered an annual physical health check. Of the nine patients on the register, seven had taken advantage of the physical health check in the financial year to date. Of the 32 patients who were included in the mental health register, 27 had undergone a physical health check.

The practice had also identified the smoking status of patients over the age of 16 and offered healthcare assistant led smoking cessation clinics to these patients on one day a week.

Diabetes clinics were offered twice a week, asthma and chronic pulmonary obstructive disease and child health and vaccine clinics once a week. 'Well person' checks led by the healthcare assistant were available every morning.

The practice's performance for cervical smear uptake was better than others in the CCG area (74.2% compared to 73.9% for the CCG). There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. The nurse was responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. It was below the CCG average for childhood immunisations. The GP explained that this was a result of the influenza vaccine being gelatine based with no alternative available. Followers of certain religious beliefs would not take up the vaccine for this reason. There was a clear policy for following up non-attenders by the named practice nurse.

The uptake of seasonal flu immunisation was significantly above the CCG average. Patients in the under 65 'at risk' category receiving the immunisation was 65.92% (CCG average 49.63%) and patients over 65 was 81.06% (CCG average 71.46%).

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, and patient satisfaction questionnaires given to patients by each GP and nurse. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the patient experience survey showed the practice to be significantly higher than the CCG average in all areas surveyed. For example 92% of respondents were satisfied with the overall experience of the surgery compared with a CCG average of 80%. When asked if they would recommend the practice 77% had responded that they would, compared to the CCG average of 69%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 38 completed cards and the 37 were wholly positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive and consisted of a personal comment about the GP. We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. We saw that a side room was available to allow people to speak without fear of being overheard and the receptionist gave an example where he had used the room to speak with a refugee.

We observed a member of the public who came into the practice during our inspection who was making enquires about joining the practice list. We heard the receptionist explain things very clearly and give the person a copy of the practice information leaflet. The also told the person to think about it carefully and offered to make time to explain in more detail and answer any questions they may have.

We also observed the receptionist advising patients that he would call them when test results had been received by the practice and when prescriptions were ready for collection.

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 practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

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. For example, data from the national patient survey showed 92% of practice respondents said they confidence and trust in the GP. This compared to a CCG average of 89%. The results from the practice's own satisfaction survey showed that 81% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas which informed patents this service was available.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

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 patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The GP displayed an exceptional knowledge of the individual needs of his patients.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to online and telephone translation services as well as through the local Ujala resource centre. Notices to that effect were clearly displayed in the reception area.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training.

A specialist GP practice in Leicester met the needs of the homeless, but we were told that should patients' who were homeless present themselves they would not be turned away.

The premises and services had been adapted to meet the needs of people with disabilities with sufficient room for patients using wheel chairs or walking aids and for pushchairs. Baby changing facilities were available as was a toilet suitable for use by disabled persons.

The practice treatment rooms and consultation rooms were situated on the ground floor of the building.

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 including baby changing facilities.

Access to the service

The surgery was open from 8 am to 6.30 pm on weekdays, until 7.30 pm on Tuesdays and from 7 am on Thursdays. Telephone as well as face to face consultations were available. Appointments with the nurse were available from 9 am to 3.50 pm and all appointments could be made by telephone or in person. On-line booking of appointments was not yet available.

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.

Longer appointments were also available for people who needed them and those with long-term conditions. Home visits were made to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours until 7.30 pm on Tuesdays and from 7 am on Thursdays was particularly useful to patients with work commitments. This was confirmed by the responses on the CQC comments cards that had been completed by patients.

Appointments were available outside of school hours for younger patients, in particular to enable them to access immunisations.

We noted that the practice website was rudimentary and contained little information. We discussed this with the practice manager who confirmed that the site was under re-construction with the aid of the NHS information

Good

Are services responsive to people's needs?

(for example, to feedback?)

technology team and it would be completed as soon as they were able. In the meantime they had attempted to ensure that all necessary and essential information was available.

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 practice manager 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 including a notice in the waiting room and information in the patient information leaflet.

We looked at the complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and we saw that they were discussed at practice meetings where the subject was a standing agenda item.

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

There was clear vision that was understood by all staff. Continuity of high quality care and treatment was the practice's priority. We spoke with three members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. The GP told us that the future held some uncertainty as he was the sole practitioner and would obviously retire at some time. There was no succession planning in place in the event that the GP ceased to practice, although he was working alongside and in collaboration the CCG to try and recruit a salaried GP to work on a part time basis.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All of the policies and procedures we looked at had been reviewed but we did note that some had not been recently reviewed to ensure their accuracy and relevance. The practice manager was aware of the shortcoming and stated they were in the process of reviewing all of the policies.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a nurse lead for infection control and the GP was the lead for safeguarding. Members of staff 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 it was performing in line with national standards.

The practice participated in The Quality, Innovation, Productivity and Prevention (QIPP) programme, a large-scale programme developed by the Department of Health to drive forward quality improvements in NHS care. We saw that the subject was discussed at all practice meetings.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as health and safety. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice held monthly practice meetings that were attended by all staff. We looked at minutes from the three meetings and found that performance, quality and risks had been discussed. They were standing agenda items at practice meetings.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. 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 was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff. All policies were available for staff to access on the practice computer system.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and saw that the practice had scored consistently high in areas of patient satisfaction and significantly above the average for the CCG in all areas. Of particular note was that the practice had scored 100% and was ranked number one nationally with regard to the helpfulness of the receptionist.

We reviewed a report produced by an external organisation, which had sought the views from patients and was dated December 2014. The survey had addressed a wide range of issues including the availability of appointments, attitude of reception staff, care and treatment and the surgery environment. Results had been positive. No common areas for improvement had been identified.

We saw that a notice thanking patients for taking part in the surveys and the results was displayed in the waiting room.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups; including members from the black and Asian communities. The PPG met every two months and members also participated in the local PPG forum. We met with two members of the group who told us that both the GP and practice manager were open to suggestions and ideas to help improve the service, for example the need for the practice to embrace on-line appointment booking.

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

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

Staff 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 regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development.

The practice had completed reviews of significant events and other incidents and shared with staff at practice meetings.