Melbourne Street Surgery

Quality Report

Melbourne Street Surgery
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Date of inspection visit: 14 November 2014
Date of publication: This is auto-populated when the report is published

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

We carried out an announced comprehensive inspection at Melbourne Street Surgery on 14 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people who circumstances may make them vulnerable, and people experiencing poor mental health.

Our key findings were as follows:

- Systems were in place to ensure the environment and equipment were clean and staff followed hygienic procedures to minimise the risk of infection.
- The practice worked in partnership with midwives, health visitors and school nurses to share information, concerns, and best ways to support families.
- Patients described the staff as friendly and caring, and said that they felt that they treated them with respect and dignity.
- Patients were involved in decisions about their health and treatment, and received support to cope emotionally with their care and condition
- There was good teamwork, leadership, and commitment to improving the quality of care and patients experiences.

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

The provider should:

- Update arrangements processes and systems to ensure that emergency drugs and equipment are available for the doctor's bags.
- Ensure the safeguarding adult's policies and procedures and the whistleblowing policy are up to date and in line with internal reporting procedures. The whistleblowing policy should include contact organisations and current guidance on how to raise concerns at work.

Summary of findings

- Ensure that staff have the necessary knowledge and understanding in relation to the Mental Capacity Act 2005 to apply the principles of the Act when necessary.
- The practice should review their arrangements for recruitment to ensure that appropriate risks assessments and checks are completed when necessary.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. The whistleblowing policy and procedure were out of date and need to be reviewed. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Systems were in place to ensure the environment and equipment were clean and staff followed hygienic procedures to minimise the risk of infection. Risks to patients were assessed and well managed. The arrangements for the medicines in the doctor's bag were not well organised and emergency medicines need to be reviewed and managed. Sufficient staffing levels were provided to meet patients' needs.

Are services effective?

Good

The practice is rated as good for effective. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patients' needs were assessed and their care and treatment was delivered in line with current evidence based practice and legislation. Effective audits were carried out to monitor the quality of care and to improve the outcomes for patients. Multidisciplinary working was evident. Staff had the skills, knowledge and experience and were supported to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for caring. Patients described the staff as friendly and caring, and said that they felt that they treated them with respect and dignity. Patients were involved in decisions about their health and treatment, and received support to cope emotionally with their care and condition. Staff were respectful, polite and friendly when dealing with patients. Patients whose first language was not English could be provided with an interpreter to help them to understand the care and treatment they needed.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Area Team (AT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The appointment system was flexible but patients reported waiting on the telephone for long periods. The practice had made improvements by upgrading the phone system and the availability of more phone

Summary of findings

lines. The practice worked in partnership with other providers and organisations to meet patients' needs in a responsive way. Health visitors were accessible at the practice once a week and a midwife held antenatal care clinics at both sites to provide family care services. The practice facilities were well equipped to treat patients and meet their needs. Patients concerns and complaints were listened and responded to and used to improve the service.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was good teamwork, leadership and commitment to improving the quality of care and patients experiences. There were high levels of staff satisfaction and engagement. All staff had clear roles and responsibilities to ensure that the practice was well led. There was an active approach to seeking out new ways of providing care and treatment. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Patients 65 years and over were offered an annual health check. All patients 75 years and over were allocated a named GP to offer continuity of care to ensure that their needs were being met. Health care plans were provided for patients over 75 years, to help avoid unplanned admissions to hospital. 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. The practice was responsive to the needs of older people, including offering home visits for elderly housebound patients.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. All patients were offered an annual review including a review of their medication, to check that their health needs were being met. When needed longer appointments and home visits were available. Where possible, clinicians reviewed patients' long term conditions and any other needs at one time, to prevent them from attending various appointments. Emergency processes were in place and referrals were made for patients that had a sudden deterioration in their health. For those people with the most complex needs, a named GP worked with relevant health and care professionals to deliver multidisciplinary support and care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-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. The GP safeguarding lead regularly met with the health visitor to discuss looked after children, unborn babies and mothers, and children on the safeguarding register to share information, concerns, and best ways to support families. Immunisation rates were high for all standard childhood immunisations. The practice worked in partnership with midwives, health visitors and school nurses. Appointments were available outside of school hours to enable children to attend. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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The practice promoted good health within its younger population group. Examples included offering a confidential service to young people by providing full sexual health screening and the availability of private facilities for self-testing for chlamydia for young people between 16-24 years.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The practice provided extended opening hours to enable patients to attend in early morning or in the evening. Patients were also offered telephone consultations and were able to book non-urgent appointments around their working day by telephone, and on line. The practice offered a choose and book service for patients referred to secondary services, which enabled them greater flexibility over when and where their appointments and tests took place. NHS health checks were offered to patients over 40 years. The practice offered health promotion and screening appropriate to the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with learning disabilities. Patients with a learning disability were offered an annual health review, including a review of their medication. When needed longer appointments and home visits were available. The practice worked with multi-disciplinary teams in the case management of people in vulnerable circumstances and at risk of abuse. Carers of vulnerable patients were identified and offered support. Alcohol and drug misuse services were available to patients and were a community service. A smoking cessation service was also available.

People experiencing poor mental health (including people with dementia)

Good

Staff had received training on how to care for people with mental health needs and dementia. The practice held a register of patients experiencing poor mental health. Patients were offered an annual health check review including a review of their medicines by the practice pharmacist to ensure that medicines were prescribed appropriately and safely. A mental health worker and counsellor held regular clinics at the practice to support patients. This was a community service. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental

Summary of findings

health, to ensure their needs were regularly reviewed, and that appropriate risk assessments and care plans were in place. Patients were supported to access emergency care and treatment when experiencing a mental health crisis.	

Summary of findings

What people who use the service say

We spoke with seven patients including three members of the Patient Participation Group (PPG). The PPG includes patient representatives who work with the practice to improve the quality of care and services. Prior to the inspection, CQC received 22 comment cards from patients at both sites. We also spoke with representatives from four care homes (for older people and younger adults) where patients were registered with the practice.

Patients and representatives told us they were generally satisfied with the care and service they received. Patients we spoke with and PPG members told us they did not find it easy to get through to the practice by phone or access appointments at times.

Representatives from three homes told us there had been difficulties arranging emergency care plans for patients. Representatives from the care homes told us patients were involved in decisions about their care and treatment, and were satisfied with the care and service they received. They were promptly referred to other services and received test results, where appropriate.

Representatives of the PPG told us they worked in partnership with the practice. Patients were asked for their views, and their feedback was acted on to improve the service. The PPG carried out a patient survey in 2013, which 148 patients completed. 90% of those surveyed said that they would recommend the practice to their friends and family, and 63% said that they were generally very satisfied with the care.

Areas for improvement included access to appointments and getting through to the practice by phone.

In response to the surveys, the practice had completed an action plan to address areas requiring improvement. Some actions had been completed and others were planned for 2015.

Areas for improvement

Action the service SHOULD take to improve

Update arrangements processes and systems to ensure that emergency medicines and equipment are available for the doctor's bags.

Ensure the safeguarding adult's policies and procedures and the whistleblowing policy are up to date and in line with internal reporting procedures. The whistleblowing policy should include contact organisations and current guidance on how to raise concerns at work.

Ensure that staff have the necessary knowledge and understanding in relation to the Mental Capacity Act 2005 to apply the principles of the Act when necessary.

The practice should review their arrangements for recruitment to ensure that appropriate risks assessments and checks are completed when necessary.

Melbourne Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead Inspector. The team included a GP specialist advisor, an additional CQC inspector, a practice manager and an expert by experience. An expert by experience is someone with experience of using services that helps us to make judgements.

Background to Melbourne Street Surgery

Johnson Medical Practice is also known as Melbourne Street Surgery and is in the Highfield's area of Leicester. The practice has approximately 2,500 patients. The practice is located in non-purpose built premises. The practice has a higher percentage of younger patients aged between 25 to 39 years. The patient group is made up of black minority ethnic (BME) 62% compared to the local clinical commissioning group (CCG) data of 49%. The range of services provided includes minor surgery, minor injuries, maternity care, blood testing, vaccinations, mental health, drug and alcohol services and various clinics for patients with long term conditions.

The practice employs three GP partners, two salaried GPs (one of whom is in the process of becoming a partner) and two long term GP locums. The practice provides 48 clinical GP sessions weekly at both practices. The practice is in the process of recruiting two nurses. There are one locum nurse, two health care assistants, a phlebotomist and a practice pharmacist. There are seven administrative and IT staff, one complaints manager, one practice manager and a full time medical secretary. The practice is a training practice for doctors in training and takes on Registrars and medical students. A registrar is a fully qualified doctor working in the surgery to develop their skills in general practice.

Johnson Medical Practice has two practices, Melbourne Street Surgery and Hilltop Surgery were visited on the same day and the policies, process, staff and systems were shared across two sites.

The practice opted out of providing the out-of-hours service. This service is provided by the out-of-hours NHS 111 service. The practice holds a GMS (General Medical Services) to deliver essential primary care services.

The practice works within Leicester City CCG (Clinical Commissioning Group). A CCG is an NHS organisation that brings together GPs and health professionals to take on commissioning responsibilities for local health services.

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 practice 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.

Detailed findings

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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed information about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 14 November 2014 at Melbourne Street Surgery and Hilltop Surgery. During our visit we checked both premises and the practice's records. We spoke with various staff including, three GPs, practice pharmacist, phlebotomist and a healthcare assistant, reception and clerical staff, the practice manager and complaints manager. All staff regularly worked across both sites We reviewed comment cards where patients shared their views and experiences of the service. Comment boxes and cards had been provided by the Care Quality Commission (CQC) before our inspection took place. We spoke with patients and representatives who used the service, including three members of the Patient Participation Group (PPG) that represented patients from both sites. The PPG includes representatives from various population groups, who work with staff to improve the service and the quality of care. In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice.

Good

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, significant events, national patient safety alerts as well as comments and complaints received from patients.

Records showed that safety incidents and concerns were appropriately dealt with. Risks to patients were assessed and appropriately managed. A system was in place to ensure that staff were aware of national patient safety alerts and relevant safety issues, and where action needed to be taken. We reviewed incident reports and minutes of meetings where incidents were discussed from the last 12 months**.** This showed the practice had managed incidents consistently over time, and so could evidence a safe track record. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

Learning and improvement from safety incidents

Staff told us that the practice was open and transparent when things went wrong. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report safety incidents and near misses. For example a GP told us about an incident with an aggressive patient who demanded a medicine. The doctor was unable to find the panic button and had to verbally call for help. The incident was managed appropriately. Drills were held regularly for staff to test the panic buttons. However one non-clinical staff member was not aware of the incident or the regular panic button drills. The practice manager agreed to brief all staff to ensure they were familiar with safe systems, and lessons learnt were shared.

The practice has a system in place for reporting, recording and monitoring significant events, incidents and accidents. We found such matters they had been investigated efficiently and effectively with good evidence collection and root cause analysis. We saw that they had been discussed at meetings. Staffs including receptionists, administrators and nursing staff were aware of the system for raising issues and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

We spoke with five clinical and non-clinical staff who were aware of the reporting mechanism for safeguarding concerns. Staff were aware of the safeguarding and whistleblowing policies. They were aware of possible types of abuse and who to report alerts to within the practice the safeguarding lead. Staff spoken with were also aware of external organisations to report safeguarding concerns to if they needed. Staff showed inspectors where policies and procedures were stored and also a poster containing relevant contact telephone numbers.

The safeguarding children's policy contained appropriate information for the practice in relation to internal and external referral. The safeguarding vulnerable adult's policy did not contain information relating to the internal procedure for staff to follow, although staff were aware of action they would need to take. This policy did contain information relating to external organisations.

Staff were aware of the practice's whistleblowing policy, what whistleblowing was, and how to report any concerns both internally and externally if required. The practice's whistleblowing policy contained information regarding internal procedures but the external procedures were outdated and had not been updated.

All staff we spoke with said that they had received safeguarding training specific to their role, except for one staff member. For example, all GPs had completed level 3 training. There was a safeguarding lead at the practice. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to share information, record safeguarding concerns and how to contact the relevant agencies. Following the inspection, we received assurances that all staff had received the above training

The practice had a register of children at risk, which contained information passed to them from Social Services. The practice was proactive in recognising the support needs of expectant mothers who may be living in vulnerable circumstances. Quarterly meetings took place with the health visitor and the GP safeguarding lead to discuss children at risk. This information was shown as an alert on the practice's electronic system, SystmOne.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone

training had been undertaken by staff, including health care assistants and reception staff. Staff understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. A member of staff who had received chaperone training was always available to clinicians.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on electronic records SystmOne which collated all communications about the patient including scanned copies of patient records communications from hospitals. 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. The lead safeguarding GP was aware of vulnerable children and adults and electronic records demonstrated good liaison with partner agencies such as the police and social services.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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. Doctors told us they encouraged patients to take old and discarded medications to the local chemist for appropriate disposal.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under directions which had been reviewed and approved in line with national guidance and legal requirements. We saw up to date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. For example, how staff generate prescriptions, were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. The service employed a practice pharmacist and told us they had been involved in various qualitative prescribing audits in the last 12 months. For example a medicine review was conducted with the aim to find out if the existing patients could be transferred to other cost-effective medicine with similar effectiveness. The audit successfully concluded that medicines could be changed to a safer product. The audits showed improved outcomes for patients and efficiencies to the practice

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.

We looked at emergency medication availability. One GP told us they did not carry any emergency medicines in the doctor's bag. This was because these medicines would be available from the local chemists, medicines in the past had expired and had been wasted, and the practice were close to accident and emergency services. GPs need to carry a range of drugs for use in acute situations when on home visits. The practice manager confirmed the GPs did not carry any emergency medicines in their doctor's bags but would look to review this arrangement after our inspection.

Following on our inspection the practice showed us GP partners practice meeting minutes from March 2013 that GP's were working to. This confirmed all clinicians would check bags and remove drugs and staff would set up an extra emergency box specifically for home visits at each site. The boxes would to be kept on the emergency trolley (2 boxes at each site). During our inspection we did not see the additional emergency boxes. Systems were not in place in line with the practices' directives. The practice manager told us the GPs triaged each home visit request by telephone before they visited, to ascertain if they needed to take any drugs with them and which ones. They would then take the appropriate drugs that they required depending on the patient's condition.

Good

Are services safe?

Cleanliness & Infection Control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We noticed an odour in the patient's toilet. The practice manager confirmed this was due to the plumbing system and was an on-going issue.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and thereafter attended annual updates. We saw evidence the lead staff member had carried out audits in May 2014 and that any improvements identified for action were completed on time including obtaining pedal operated bins in the treatment rooms across both sites.

We found the disposable privacy curtains around examination couches were out of date and needed replacing at both sites. The practice manager confirmed to us these were replaced with new curtains following our inspection.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, alcohol gel, and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (water borne bacteria found in the environment which can contaminate water systems in buildings). We saw that the practice had employed an external provider to prepare an assessment of the risk from water borne bacteria including Legionella. The practice had acted upon the recommendations arising from the assessment in order to reduce the risk of infection to staff and patients.

A policy was in place relating to the immunisation of staff at risk of the exposure to Hepatitis B infection, which could be acquired through their work. The records showed that relevant staff were protected from Hepatitis B infection.

Equipment

Staff we spoke with told us they had sufficient 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 tested in June 2014 and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure machines.

Staffing & Recruitment

Records we looked at contained 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 criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We found a healthcare assistant had started work before completing an enhanced DBS check. Following on our inspection the practice manager confirmed a DBS check had been started for the staff member. The practice manager confirmed they were now aware of the current Disclosure and Barring Service guidance and agreed to check each staff member's recruitment file.

Staff told us about the arrangements for planning and monitoring the numbers and mix of staff needed to meet patients' needs. The practice sometimes used locum GPs and agency staff and had a policy and appropriate procedures in place relating to this. We saw there was a rota system in place for all the different staff groups to ensure they were enough staff on duty.

Monitoring Safety & Responding to Risk

The practice had systems and policies in place to identify, manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the premises, equipment and medicines management. Action plans were put in place to reduce and manage any risks.

Good

Are services safe?

These were discussed at GP partners' and team meetings. The practice had a health and safety policy, which staff had access to. The practice manager was the health and safety representative.

We saw that staff were able to identify and respond to risks to patients including deteriorating health and well-being or medical emergencies. For example emergency processes were in place for patients with long term conditions. Staff gave us examples of referrals made for patients that had a sudden deterioration in health.

There were emergency processes in place for identifying acutely ill children and young people.

Emergency processes were in place for acute pregnancy complications.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

The practice monitored repeat prescribing for patients receiving high risk medicines.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The training records showed that all staff had received training in basic life support. Emergency equipment was available including oxygen cylinders, nebulisers and an automated defibrillator (used to attempt to restart a person's heart in an emergency). Records showed that the emergency equipment were regularly checked with a label of next review to ensure they were fit to use and within their expiry date. GPs told us of an emergency where a patient had become dehydrated and where they had taken appropriate action. The lessons learnt were shared.

A business continuity plan was in place setting out how to deal with a range of emergencies that may impact on the day to day running of the practice such as power failure, loss of information technology, adverse weather, and access to the building. Plans were in place if any of the situations occurred to enable the practice to continue to deliver primary medical services. A fire risk assessment had been completed, which included actions required to maintain fire safety. Records viewed showed that staff were up to date with fire training and that fire drills were carried out regularly, to ensure that people knew how to evacuate the premises, and what to do in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinical staff we spoke with said that they received updates relating to current best practice and the National Institute for Health and Care Excellence (NICE) guidelines electronically. The aim of the NICE guidelines is to improve health outcomes for patients. Staff also told us that they discussed clinical issues and changes to practice at clinical meetings. The weekly minutes of meetings we looked at confirmed this. The GPs had taken on lead roles in clinical areas such as diabetes, heart disease, asthma and palliative care. The practice also provided a warfarin management clinic.

We found from discussions with the clinical staff that they completed thorough assessments of patients' needs. Systems were in place to ensure that older people, those in vulnerable circumstances, with long term conditions and experiencing poor mental health received an annual health review, including a review of their medicines by the practice pharmacist. For example patients on high risk medicines were regularly reviewed. Care plans had been established for patients on medicines that required regular blood tests as requested by the practice pharmacist. Systems were in place to recall patients for an annual review. Regular multi-disciplinary meetings were held to review the health needs and care plans of patients who had complex needs and were receiving end of life care.

The practice referred patients appropriately to secondary and other community care services. Patients were referred on the basis of need.

The practice told us that patients over 75 years had a named GP to ensure continuity of care and oversee that their needs were being met, however one care home representative told us two patients over 75 years did not have a named GP. Representatives from three homes told us there had been difficulties arranging emergency care plans for patients and accessing appointments on the telephone. These issues were passed onto the practice manager at the time of our inspection.

The practice provided antenatal and postnatal care with a midwife. There were systems in place that ensured babies received a new born and six week development assessment in line with the Healthy Child Programme.

Health Visitors were accessible at the practice once a week. Diana nurses (children's cancer nurses) were linked with the practice due to a small number of children receiving end of life care at both practices.

Management, monitoring and improving outcomes for people

Staff across the practice had clear roles in monitoring and improving outcomes for patients. The GPs 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 national performance measurement tool. Records showed that the practice achieved a total of 97.82 % in the QOF performance for 2013/ 2014. This was above the average for practices in England and locally of 94.61 %.

The team made use of audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. We saw systems were in place for completing clinical audit cycles to provide assurances as to the quality of care, and to improve the outcomes for patients. Various audits and reviews had been completed in the last year, and the practice was able to demonstrate the changes resulting from these. Audits were for all patients across the two sites. One of the audits was to find out reasons for unplanned admission among the elderly aged over 65 years. The outcome was ensuring patients had care plans and a named GP to reduce the unplanned admissions.

Staff told us that the outcome of audits was communicated through the team and clinical meetings. Records showed that weekly clinical meetings were held involving the GPs and nurses. These meetings enabled staff to discuss clinical issues and peer review each other's practice, driving improvements in care.

The practice was involved in various projects to improve outcomes for patients and to enable more people to be treated locally by GPs. For example patients at risk of developing a chronic respiratory condition and coronary artery disease were offered screening to enable the conditions to be detected and treated early. The practice were part of a cardiology project to enable GPs to support patients with mild to moderate heart failure. This enabled more patients to be treated locally by GPs.

Effective staffing

We found that the practice had an established staff team with appropriate knowledge, skills and experience to

Good

Are services effective?

(for example, treatment is effective)

enable them to carry out their roles effectively. The training records showed that most staff were up to date with training such as safeguarding and basic life support. The practice closed for half a day each month to enable all staff to receive protected learning time. Further staff training needs had been identified and planned for.

The clinical staff had received comprehensive training from specialist staff to enable them to care for more patients who had diabetes and reduce the need for hospital referrals. Two of the GP partners were End of Life Care mentors, and had received comprehensive training on palliative care. This enabled them to provide advice and support to clinicians including other GP practices in Leicester City, to ensure that patients received appropriate care.

Staff told us they worked well together as a team. They also said that they were supported to maintain and develop their skills and knowledge. For example one member of staff told us they were booked to receive a training update in smoking cessation and spirometry training to undertake certain cardio vascular and pulmonary checks.

Staff told us that they received annual appraisals which identified their learning needs from which action plans were recorded. Some staff confirmed their appraisals were due in January 2015.

The practice manager told us that all GPs were up to date with their professional development requirements, and had either been revalidated or had a date for revalidation. (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).

Working with colleagues and other services

Records showed that the practice held regular multi-disciplinary team (MDT) meetings to discuss patients with complex needs, including those with end of life care needs, or in vulnerable circumstances. These meetings were attended by social care staff, an older people community psychiatric nurse, a palliative care nurse, heart failure nurses, and a community matron and care navigators. Care navigators were employed by Leicester City Council and funded by Leicester City Clinical Commissioning Group in a joint commitment to improve and retain good general health and wellbeing in older patients over 75. The role of the care navigator was to support those patients over 75 who are identified as at the greatest risk of a hospital admission so they maintain their independence and stay in their own homes longer when it is appropriate and safe to do so.

The lead GP for safeguarding children told us they worked closely with health visitors, school nurses, looked after children nurse, and safeguarding midwife. The GP would ensure they were contactable by other local practice staff in case of emergencies by mobile phone, direct discussion and through SystmOne messages and tasks. The GP would meet every three months with the community health visitor and school nurse to discuss children on the at risk register and develop a plan of care.

The practice had signed up to the enhanced service to avoid unplanned admissions and to follow up patients discharged from hospital. (Enhanced services are additional services provided by GPs to meet the needs of their patients). It was clear from discussions with staff that considerable work went into supporting people to remain in their own home, and ensuring they received appropriate support on discharge from hospital.

Information Sharing

A shared system was in place with the local out-of-hours provider to enable essential information about patients to be shared in a secure and timely manner. For example, the practice worked closely with the out-of-hours service to ensure that staff providing emergency cover, had access to essential information about patients' needs, including end of life wishes and specific health issues to help avoid unnecessary admissions. The practice used SystmOne electronic system to coordinate records and manage patients' care. All staff were trained on the system, which enabled scanned paper communications, such as those from hospital, to be saved for future reference. For patients requiring emergency assessment or admission to hospital the GPs provided a printed summary record for the patient to take with them. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key information within 24 hours).

Electronic systems were also in place for making referrals. The Choose and Book system enabled patients to choose which hospital they wished to be seen in, and to book their own outpatient appointments.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Patients told us that they were involved in decisions about, and had agreed to, their care and treatment. They also said that they had the opportunity to ask questions and felt listened to. We found that arrangements were in place to ensure that patients consent was obtained before they received any care or treatment, and that staff acted in accordance with legal requirements. Written consent was obtained for specific interventions such as minor surgical procedures, together with a record of the possible risks and complications.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans. Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. Clinical staff understood the importance of determining if a child was Gillick competent especially when providing treatment and contraceptive advice. We saw examples where this had been applied at both practices. (A Gillick competent child is a child under 16 who is capable of understanding implications of the proposed treatment, including the risks and alternative options).

Most staff were aware and had an understanding of the Mental Capacity Act 2005 and their responsibilities to act in accordance with legal requirements.

Minutes of a clinical meeting held on 18 June 2014 confirmed the GPs wanted to update themselves on consent to treatment but this training had not been arranged. Completion of this training was also linked to the outcome of a recent complaint and lessons learnt. Some clinicians we spoke with said they would welcome further training.

It was clear from discussions with clinical staff that arrangements were in place for patients receiving end of life care. All patients who were part of the admission avoidance scheme had an "emergency health care plan" to ensure that their wishes were respected, including decisions about resuscitation and where they wished to die. Staff at the practice communicated regularly with Macmillan nurses visiting patients at home and with Leicestershire and Rutland Hospice (LOROS). The Leicestershire and Rutland Hospice is a specialist centre providing skilled nursing and medical care, supported by physiotherapists, occupational therapists and social workers, in an environment that recognises the particular needs of patients and their families.

Practice staff worked closely with Rainbows and Diana Nurses around palliative care services for children and young adults up to the age of 18 years. This information was available to the out-of- hour's service, ambulance staff and local hospitals.

Health Promotion & Prevention

We saw that a wide range of health promotion information was available to patients and carers on the practice's website, and the noticeboards.

The practice helped the patient population groups to live healthier lives. Smoking cessation clinics were run by health care assistants and patients could be referred to external organisations. It was practice policy to offer all new patients registering with the practice a health check with the health care assistant. The GP was informed of all health concerns detected and these were followed up appropriately.

The practice offered NHS Health Checks to all its patients aged 40-74 years.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. Alcohol and drug abuse services were available. We found the practice had joint working arrangements with a local mental health service called Improving Access to Physiological Therapies (IAPT). The service supported patients with mental health needs and provided access to IAPT counsellor and an advanced mental health nurse. We saw that the practice had developed links with local services such as specialist nurses and other local healthcare providers to ensure seamless referral pathways for patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013/14 data for immunisations showed that the practice was above average for the area CCG, and there was a system in place for following up patients who did not attend.

The practice offered NHS Health Checks to all patients aged 40 to 74 years. Patients were also encouraged to attend relevant screening programmes including cervical smears. A recall system was in place for following-up patients who did not attend screening. The practice had met 80% of the referrals across both sites. All patients with a learning disability, poor mental health, long standing conditions or aged 75 years and over were offered an annual health

Good

Are services effective?

(for example, treatment is effective)

check, including a review of their medication**.** Those patients on lithium medicine therapy were asked to come to the practice regularly to have their blood levels monitored by the GP or nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients had completed Care Quality Commission (CQC) comment cards to provide us with feedback. Most patients said they felt the practice offered an excellent service and staff were helpful and caring. They said staff treated them with dignity and respect. Most complained about the length of time holding on the telephone to get through to make an appointment. We also spoke with three members of the patient participation group (PPG). 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 were 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 found when patients queued at reception, people could hear their conversations with reception staff. This was due to the construction and design of the building. The practice manager agreed to raise this with the partners and the PPG.

Care planning and involvement in decisions about care and treatment

The 2013 national 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. We found from data that 77% of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care. We found 83% of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. This data was relevant to the whole 11000 patient population across both sites.

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. Double appointments were offered for vulnerable patients to ensure protected time with the GP was appropriate.

We checked the storage of written patient's records. Records were stored in an area not accessible by the public and were secure.

Patient/carer support to cope emotionally with care and treatment

The practice's computer system alerted the GP if a patient was also a carer. Carers were referred to social services so that appropriate support could be provided. Further information to assist carers were found on the practice website. Patients were encouraged to involve their carers in their care and treatment plans if they wished to do so. The practice sent compliment cards to keep in contact with carers.

We found notices in the patient waiting room, on the information screen, and patient website signposted patients to a number of support groups and organisations. We found disabled access and loop hearing facilities were available.

Staff told us families who had suffered bereavement were telephoned by their usual GP and sent a sympathy letter. This call was either followed up by a patient consultation at a flexible time and location to meet the family's needs and/ or signposting to a support service. Patients we spoke with who had experienced a recent bereavement confirmed they had received this type of support and said they had found it helpful. Support was available from CRUSE a support telephone line, and bereavement counselling was provided by Leicestershire and Rutland Hospice (LOROS). A spiritual counsellor was available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Representatives of four care homes we spoke with told us they were generally satisfied with the care and service they received. One representative told us accessing appointments on the telephone was difficult and would be kept waiting for some time. Patients and PPG members told us they did not find it easy to get through to the practice by phone or access appointments at times. The practice manager told us they were aware of the difficulties around the telephone lines at both sites and were taking steps to address this. The practice had upgraded the phone system and the availability of more phone lines.

Representatives from the care homes told us patients were involved in decisions about their care and treatment, and were satisfied with the care and service they received. Patients were seen where required and their needs were regularly reviewed They were promptly referred to other services and received test results, where appropriate, preventing health issues from becoming more serious.

We found the practice provided a wide range of services to meet patients' needs, and enable them to be treated locally. For example, the practice employed a phlebotomist to enable patients to have their blood tests done at the practice or in the patient's home. Patients care and treatment was coordinated with other services and providers. The services were flexible, and were planned and delivered in a way that met the needs of the local population.

The practice had a proportion of black minority ethnic (BME) patients. However many staff at the practice spoke a number of Asian languages including Gujarati, Hindi and Urdu which enabled them to communicate effectively with many patients who used the practice. Translation services were available for patients who did not have English as a first language. Staff told us they had used the translation services recently to assist Polish and Slovakian speaking patients.

Antenatal care and support to younger children was provided by the designated midwife and health visitor (not employed by the practice but used the facilities), and held weekly clinics at both practices. The health visitor was based once a week at the practice, which enabled the GPs and staff to discuss any issues face to face. A mental health worker also held regular clinics at the practice to support patients experiencing poor mental health. Counselling services were also available. Regular multi-disciplinary meetings were held to discuss patients with complex and high risk needs, including patients receiving end of life care. This helped to ensure that patients and families received coordinated care and support, which took account of their needs and wishes.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services, and worked in partnership with other providers and services to understand the diverse needs of patients. Staff informed us they operated an open list culture, accepting patients who lived within their practice boundary. The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training and that equality and diversity were regularly discussed at staff appraisals and team events. One staff member told us about training about forced marriages and being aware of the issues for patient groups.

The practice made use of an alert system on the computerised systems to help them to identify patients who might be vulnerable or have specific needs This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review and patients receiving palliative care. The alert system also identified risks to enable clinicians to consider issues for their consultations with patients such as children who were known to be at risk of harm.

The alcohol and drug abuse service staff worker worked closely with relevant services to support families and patients who had a drug dependency. Patients with mental health needs could access the IAPT (Improving access to psychological services) counsellors, advanced mental health reviews with clinicians and support from the practice pharmacist.

Home visits and longer appointments were available for patients who needed them, including people in vulnerable circumstances, experiencing poor mental health, with complex needs or long term conditions.

Access to the service

The practice was open from 8am Monday to Friday. Monday evening the practice closed late at 8.00pm and Tuesday to

Good

Are services responsive to people's needs?

(for example, to feedback?)

Friday 6.30pm. This enabled children and young people to attend appointments after school hours. It also enabled working age patients and those unable to attend during the day, to attend in an evening. We saw that systems were in place to prioritise emergency and home visit appointments. Telephone consultations were available for patients who were not well enough to attend the practice. The practice also closed for half a day once a month for clinicians training. However the practice continued to operate a service to patients.

Care home representatives, patients and PPG (patient participation group) members told us accessing appointments on the telephone was difficult and they would be kept waiting for some time. Records showed that the appointment system and telephone response times were regularly checked, to ensure that the practice responded to patients' needs. In response to people's concerns about access, the practice manager had made some improvements with more phone lines.

Patients had access to information about the appointment system, opening times and the out-of-hours service on the practice's website. The information was also available in the reception area and in the patients leaflet. The practice website provided a wide range of information about various services, and included a translation facility for people whose first language was not English to enable them to access the information.

We found that the facilities and the premises were accessible and appropriate for the services being delivered. The majority of patient facilities were on the ground floor. Patients with health or mobility difficulties were seen on the ground floor. We found when patients queued at reception, people could hear their conversations with reception staff. This was due to the construction and design of the building. The practice manager agreed to raise this with the partners and the PPG.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The complaints manager handled all complaints in the practice.

We looked at the complaints policy and the information available to help patients understand the complaints system. We found a complaints summary in the patients information leaflet was detailed on the website. Patients we spoke with were aware of the process to follow should they wish to make a complaint.

We looked at complaints records. We reviewed a complaint that had been raised with the practice. This had been investigated and changes made around patient consent to treatment forms, and consent training for clinicians. However we found from training records not all clinicians had attended the consent training. The practice had not made arrangements to ensure all clinicians attended the training. They practice manager gave assurance's this training would be provided following on our inspection.

We saw formal complaints were acknowledged within three days and complaints investigation undertaken and the complainant kept informed of the process. A lead GP would oversee the overall management of complaints investigations. In the last twelve months we looked at three complaints and found these were generally satisfactorily handled, and dealt with in a timely way.

In addition to the formal complaints system comments cards were available at the reception area, to enable patients to express their views and ideas about how the service could improve. We saw that a number of patients had completed these in the last 12 months. The complaints manager reviewed the comments cards and complaints received each month to identify any patterns, and to ensure that the information was acted on. Staff told us that the findings of complaints were shared with the team so that lessons were learnt and that changes were made where needed. Records we looked at supported this. Clinicians meetings in June and August 2014 showed complaints analysis were discussed to ensure staff were aware and able to learn and contribute to on-going improvement. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

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 a clear vision and strategy to deliver high standards of patient's care incorporating a holistic approach towards diagnosis and management of illness. A clear business plan was in place, which set out the plans for 2013-2015. The plans included engagement with medicine management by taking part in prescribing incentive schemes, continued engagement with the primary care research networks research projects, continue and improve staff training. Improvements over the last 12 months included developing the website to ensure it met patients' needs, upgrading the phone system and the availability of more phone lines.

Governance Arrangements

We found that there were effective governance arrangements in place and that staff were aware of their own roles and responsibilities. For example, we saw that some staff members had designated lead roles for different aspects of the practice's business. This included roles such as safeguarding lead, infection control lead, mental health and dementia lead and complaints handling lead.

Records showed in 2014 qualitative and cost effective audits were carried out as part of quality improvement process cycle with more audits to be completed by March 2015. These showed that essential changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment. Decisions, including any learning from significant events, were disseminated to staff, at staff meetings. Staff we spoke with told us that they felt the communication from the management team was very good and that they felt they were kept up to date.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We found some of the policies and procedures safeguarding and whistleblowing policies needed review and update.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

It was evident from our interviews with the management team, the GPs and the staff that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. For example staff at all levels could share concerns about risks to individual patients with a clinician even if they were unsure about what they had identified. We saw that the practice recognised and rewarded good practice and staff told us that they felt valued and supported by the management team. All staff were enabled to maintain their professional knowledge by attending protected training events where they could focus on their learning and development uninterrupted by regular duties

The practice is a training practice for doctors in training and takes on Registrars and medical students. A registrar is a fully qualified doctor working in the surgery to develop their skills in general practice. Following on our inspection the practice told us the led GP trainer had left, and another GP was training to be the lead trainer.

The aims and values of the service were clearly set out in the practice business plan. The aim for the staff team was: "To support each other and the patients journey, in a fashion of evidenced based healthcare which you would find acceptable for a close family member." Staff were committed to providing high quality, safe and effective care and services, and they were proud of their achievements as a team in the last 12 months.

Practice seeks and acts on feedback from users, public and staff

The practice obtained feedback from patients through the national GP patient survey and complaints. The practice had a Patient Participation Group (PPG), which includes representatives from various population groups, who work with staff to improve the quality of care and services for patients. We spoke with three members of the PPG that represented patients from both sites. They told us they had tried to enlist members to represent younger people via the PPG notice boards in the waiting rooms, and at an open day at the practice. The practice manager always attended their monthly meetings and where possible a GP attended. They felt the service was much better than 12 months ago. They also said that the practice valued their role, and asked for their views to improve the service.

The PPG carried out a patient survey in 2013. The results and actions agreed from recent surveys were available on

Are services well-led?

Good

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

the practice website and at the practice. These provided assurances that patients were asked for their views, and their feedback was acted on to improve the service. Areas for improvements were: Improve communication with patients, appointment availability and telephone access. We saw the action plan with timescales for final completion in March 2015. Some work had been completed around regular newsletters and notice boards updated for patients with key information. PPG members and patients confirmed the text messaging service worked well. The practice manager and the GPs told us of the changes the practice had been through over the last two years.

There was an active approach to seeking out new ways of providing care and treatment. Discussions with staff and records showed that the practice obtained feedback from staff through sharing information at multi -disciplinary meetings (MDT), team meetings and appraisals. Staff said that they felt involved in decisions about the practice, and were asked for their views about the service to improve outcomes for patients and staff.

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 & improvement

Staff said that they were supported to maintain and develop their skills and knowledge. Records showed that staff received on-going training and development and an annual appraisal to enable them to carry out their work effectively. Records showed that accidents, incidents and significant events were reviewed to identify any patterns or issues, and that appropriate actions were taken to minimise further occurrences. Minutes of practice meeting showed that appropriate learning and improvements had taken place, and that the findings were communicated widely attended.