St Peter's Medical Centre - Mansingh and Mehra

Quality Report

St Peter's Health Centre
Sparkenhoe Street
Leicester
LE2 0TA
Tel: 0116 2707067
Website: No website

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St Peter's Medical Centre on 6 January 2015.

Overall the practice is rated as Requires Improvement.

Specifically, we found the practice inadequate for providing safe care. It was requires improvement for the responsive and well-led domains. Required Improvement for providing services for all the population groups, It was good for providing effective and caring services.

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.
- Patients said service received was good. Receptionists were friendly and helpful
- Immunisation rates were 96% and above the Clinical Commissioning Group (CCG) average.
- Data showed patient outcomes were average for the locality within the CCG.
- Some clinical audits had been carried out but we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- In the July 2014 national GP patient survey 81% patients described the overall experience as good which was average for the CCG.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had not proactively sought feedback from staff or patients.

The areas where the provider must make improvements are:

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include the checking of medical equipment, fridge temperatures and disclosure and barring for staff recruitment.

Summary of findings

- Identify, assess and manage risks relating to the health, welfare and safety of patients, staff and other people who may be at risk within the practice. For example, risk assessments for, legionella, oxygen, general office environment, control of substances hazardous to health (COSHH), use of a chaperone and infection control.
- Regard should be made to information available and patient views in delivering services and driving improvements.
- Ensure its recruitment arrangements and necessary employment checks are in place for all staff.
- Ensure that staff have appropriate support, identified through a formal appraisal system to have the necessary training to enable them to deliver the care and work they carry out in the practice.
- Put in place an effective system to regularly assess and monitor the quality of the service provided by St Peter's Medical Centre. For example, ensure staff have clear guidance and the practice manage and learn from significant events and complaints.

In addition the provider should

- The practice should have a patient participation group (PPG) in order for patients and the practice to work together to improve the service and improve the quality of care patients receive.
- The practice should have policies in place in areas relating to whistleblowing and legionella. to provide guidance and support to staff.
- Policies and procedures should be reviewed to ensure that they are reviewed, updated and do not contain contradictory information, for example, the chaperone protocol.
- Have a clear audit programme to improve the quality of patient outcomes.
- Identify and deliver training and awareness to staff so they can deliver care safely and to an appropriate standard, for example, chaperone and Mental Capacity Act 2005.
- Offer patients the opportunity to have an annual physical health check.

Where, as in this instance, a provider is rated as inadequate for one of the five key questions or one of the six population groups it will be re-inspected no longer than six months after the initial rating is confirmed. If the provider is inadequate for more than one key question they will go straight into special measures.

If, after re-inspection, it has failed to make sufficient improvement, and is still rated as inadequate for a key question or population group, we will place it into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. There was insufficient information to enable us to understand and be assured about safety because when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. The practice did not have robust arrangements in place to ensure medical equipment was regularly checked as per practice policy. Fridges used to store medicines did not have their temperatures checked daily as per national guidance to ensure the efficacy of the medicines. We did not see evidence of a robust system to ensure an appropriate standard of cleanliness and infection control, for example checks on cleaning standards and infection control audits. The practice did not identify, assess and manage risks relating to the health, welfare and safety of patients, staff and other people who may be at risk within the practice. For example, risk assessments for legionella, oxygen, general office environment, control of substances hazardous to health (COSHH), use of a chaperone and infection control.

Are services effective?

Good

The practice is rated as good for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. Staff referred to guidance from NICE and used it routinely There were no completed audits of patient outcomes. Staff had received training appropriate to their roles but further training needs had not been identified and planned. We saw the practice had carried out audits. The practice had evidence to demonstrate some improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

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

Summary of findings

about their care and treatment. The practice did not have a website so information to help patients understand the services was not readily available. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Feedback from patients reported that access to a named GP and continuity of care was always available and urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. Information about the complaints system was not freely available to patients. There was no complaints information displayed in the practice. There was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. There was a documented leadership structure and most staff felt supported by management. The practice had a number of policies and procedures to govern activity, but some of these were overdue for review. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. The practice had sought limited feedback from staff and patients but there was no evidence to show they had responded to concerns to improve the practice. The practice did not have a patient participation group (PPG). Staff told us they had not received regular performance reviews and did not have clear objectives.

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

Requires improvement

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

The provider was rated as good for effective and caring overall and this includes this population group.

The provider was rated as inadequate for safety, requires improvement for responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Care and treatment of older people did not always reflect current evidence-based practice, and some older people did not have care plans where necessary. Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients. The leadership of the practice had started to engage with this patient group to look at further options to improve services for them. Personalised care plans were in place for patients at end of life. Patients at high risk had been identified to reduce admissions to secondary care. Where admissions to secondary care had occurred 100% of patients had been followed up. 100% of people receiving structured annual medication reviews for polypharmacy. Polypharmacy is the use of four or more medications by a patient, generally adults aged over 65 years. 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

Requires improvement

The practice is rated as requires improvement for people with long-term conditions.

The provider was rated as good for effective and caring overall and this includes this population group.

The provider was rated as inadequate for safety, requires improvement responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Emergency processes were in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments

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and home visits were available when needed. However, not all these patients had a named GP or a personalised care plan or structured annual review to check that their health and care needs were being met.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the families, children and young people.

The provider was rated as good for effective and caring overall and this includes this population group.

The provider was rated as inadequate for safety, requires improvement responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly. The practice could refer any pregnancy complications to the Early Pregnancy Assessment Unit or for admission as appropriate. Cervical smear uptake was 69.9% which was below the CCG average.

Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours. Young people were signposted to local sexual health clinics. Last year's performance for all immunisations was 96% and above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

Working age people (including those recently retired and students)

Requires improvement

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

The provider was rated as good for effective and caring overall and this includes this population group.

The provider was rated as inadequate for safety, requires improvement responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. Although the practice offered extended opening hours for appointments from Monday to Friday.

The practice did not have a website for patients to gain information about the practice. However if they were registered for on-line services they could book/cancel appointments and order repeat prescriptions. NHS Choices also provided information about the practice. They had a practice leaflet which did not make reference to NHS Choices, online services for the practice health promotion or practice policies,

Only 23.4% of patients aged 40-74 had received a NHS Health check.

Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

People whose circumstances may make them vulnerable

Requires improvement

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

The provider was rated as good for effective and caring overall and this includes this population group.

The provider was rated as inadequate for safety, requires improvement responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living vulnerable circumstances including homeless people, travellers and those with a learning disability. 87% of patients with a learning disability had received an annual health check.

The practice 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.

People experiencing poor mental health (including people with dementia)

Requires improvement

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

The provider was rated as good for effective and caring overall and this includes this population group.

Summary of findings

The provider was rated as inadequate for safety, requires improvement responsive and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

80% of people experiencing poor mental health had received an annual physical health check. The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health but not always those with dementia. Cognition testing had just commenced in the practice at the time of the inspection. It carried out advance care planning for patients with dementia. Patients with mental health problems were referred to the Crisis Team. Access was available with St Peter's Health Centre where patients could be referred by a GP to a psychiatric clinic. Repeat prescribing of medicines was done as a shared care protocol with the psychiatrist.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND. MIND is a mental health charity in England and Wales. It offers information and advice to people with mental health problems. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Most staff had received training on how to care for people with mental health needs.

Summary of findings

What people who use the service say

We reviewed 46 comments cards that had been completed and left in a CQC comments box. The

comment cards enabled patients to express their views on the care and treatment received.

Most of the comment cards reviewed were extremely positive. 44 described very good care given by staff who were caring, understanding and responsive. Two was less positive appointments and a doctor not having time to listen being the main issues. We spoke with the management team who told us that these issues were actions which the practice would look at and make improvements to.

In the July 2014 national GP patient survey 81% patients described the overall experience as good.88% had confidence or trust in the last GP/nurse they spoke with and 74% said they were involved in decisions about their care.

The practice had commenced the Family and Friends testing (FFT) on 1 December 2014. FFT will enable patients to provide feedback on the care and treatment provided by the practice.

We looked at NHS Choices. In 2014 the practice had received two positive and two negative comments. Negative comments with regard to attitude of reception staff and positive comments about how helpful the practice was, praise for all the staff and would recommend the practice to relatives and friends.

Areas for improvement

Action the service MUST take to improve

- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include the checking of medical equipment, fridge temperatures and disclosure and barring for staff recruitment.
- Identify, assess and manage risks relating to the health, welfare and safety of patients, staff and other people who may be at risk within the practice. For example, risk assessments for, legionella, oxygen, general office environment, control of substances hazardous to health (COSHH), use of a chaperone and infection control.
- Regard should be made to information available and patient views in delivering services and driving improvements.
- Ensure its recruitment arrangements and necessary employment checks are in place for all staff.
- Ensure that staff have appropriate support, identified through a formal appraisal system to have the necessary training to enable them to deliver the care and work they carry out in the practice.
- Put in place an effective system to regularly assess and monitor the quality of the service provided by St Peter's Medical Centre. For example, ensure staff have clear guidance and the practice manage and learn from significant events and complaints.

Action the service SHOULD take to improve

- The practice should have a patient participation group (PPG) in order for patients and the practice to work together to improve the service and improve the quality of care patients receive.
- The practice should have policies in place in areas relating to whistleblowing and legionella. to provide guidance and support to staff.
- Policies and procedures should be reviewed to ensure that they are reviewed, updated and do not contain contradictory information, for example, the chaperone protocol.
- Have a clear audit programme to improve the quality of patient outcomes.
- Identify and deliver training and awareness to staff so they can deliver care safely and to an appropriate standard, for example, chaperone and Mental Capacity Act 2005.

Summary of findings

- Offer patients the opportunity to have an annual physical health check.

St Peter's Medical Centre - Mansingh and Mehra

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, a second CQC Inspector and a GP practice manager.

Background to St Peter's Medical Centre - Mansingh and Mehra

St Peter's Medical Centre is situated within St Peter's Health Centre. The health centre brings together a wide range of health care professionals. The building is a shared occupancy and comprised of two GP practices and a range of other health care services.

St Peter's Medical Centre – Dr Mansingh and Mehra provide Primary Medical Services for 2,800 patients in Leicester City.

At the time of our inspection the practice employed two GP partners(male), one practice manager, one assistant practice manager, one Quality and Outcomes Framework (QOF) co-ordinator, one nurse, one health care assistant and two reception and administrative staff. (QOF) is a system used to monitor the quality of services in GP practices.

The practice manager had been promoted to the post in Summer 2014 and was still in a period of induction. He had peer support from the previous practice manager who was available on a day to day basis. The practice manager told us he felt well supported.

The practice has a Primary Medical Services Contract (PMS). A PMS contract is a local contract agreed between NHS England and the practice, together with its funding arrangements.

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

St Peter's Medical Centre, St Peter's Health Centre, Sparkenhoe St, Leicester. LE2 0TA.

We did not visit Queens Road Surgery, 282 Queens Road, Leicester, LE2 3FU as it is registered as a separate location.

The CQC intelligent monitoring placed the practice in band four. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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

Detailed findings

Leicester City is one of the most diverse and disadvantaged urban areas in the country. Leicester has a young population. About 60% of people living in Leicester are under the age of 40 and there are fewer people aged 65 and over compared to the national average. Approximately 50% of patients are from

ethnic minorities, with nearly a third of the population being South Asian. The city has the largest Indian population of any local authority area in England, while it also has thriving communities of people originating from Somali, middle eastern, African and eastern European backgrounds.

Leicester City have some of the most deprived areas and patients have some of the worst health of anywhere in the country. Leicester has the 20th most deprived population in England and about half

of patients are considered to be highly disadvantaged.

St Peters Medical Centre – Dr Mansingh and Mehra have opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided to Leicester City, Leicestershire and Rutland by Central Nottinghamshire Clinical Services.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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:

- 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 we hold about the practice and asked other organisations to share what they knew. We reviewed information from NHS Leicester City Clinical Commissioning Group (CCG), NHS England (NHSE), Public Health England (PHE), Healthwatch Leicestershire and NHS Choices.

We carried out an announced inspection on 6 January 2015.

We asked the practice to put out a box and comment cards in reception where patients and members of the public could share their views and experiences.

We reviewed 46 completed comment cards. 44 were positive and described very good care given by staff who were caring, understanding and responsive. Two were less positive with appointments and a GP not having time to listen being the issues raised.

We spoke with nine members of staff which included two GP's, practice manager, assistant practice manager, QOF co-ordinator, one nurse, one health care assistant and two reception and administration staff.

Detailed findings

We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Inadequate

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. 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. This showed the practice had managed these and could evidence a safe track record. A member of staff we spoke with told us minutes of meetings were sent electronically to all members of staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents.

Staff used incident forms completed were sent to the practice manager. We tracked seven incidents and saw records were completed in a timely manner. However we found that there had been confusion over which forms to fill in for an incident or significant event. The practice manager we spoke with the after the inspection advised us he was on a period of induction to the practice. He told us he would seek guidance from peers, update the significant event policy and ensure that all staff had further information on the correct forms to fill in.

We spoke with a health care assistant who told us of a recent significant event incident in which a vaccine had been administered to a patient twice. This was discussed at the November team meeting. Learning was discussed and the practice found that standard operating procedure had not followed.

We also saw that not all investigations were comprehensive or recorded in detail. There was limited evidence to demonstrate the actions and learning which had taken place, for example, an incident which involved a sewerage overflow did not contain information about what infection control procedures took place.

We spoke with the management team after the inspection who advised us that they would look at the process they currently had in place for the recording of significant events and ensure that future significant events and accidents were investigated , documented and information shared with staff.

There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were not reviewed to detect themes or trends.

We looked at meeting minutes for 4 September 2014 and found themes had not been identified. The minutes did not document a summary of key learning points and actions to be taken. The practice had not documented who the actions were for or a date that the actions had to be completed by. There was no evidence that the practice had shared the findings with relevant staff. We spoke with receptionists, nurse and administrative staff. All knew how to raise an issue for consideration at meetings and felt encouraged to do so.

National patient safety alerts were received by a senior GP and practice manager. National patient safety alerts (NPSA) were disseminated by email to all practice staff. A GP we spoke with demonstrated that the practice responded quickly to NPSA alerts. Checks would be made on patient records and patients would be contacted in the event of an alert. The practice had a weekly visit from a pharmacist who also highlighted any potential issues. The practice had a safety alerts procedure and we saw that the practice had developed its own software package with a section on alerts. The practice manager told us he was responsible for NPSA alerts and he checked to make sure they had been actioned by the relevant member of the practice team.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults.

The practice had a dedicated GP as lead in safeguarding vulnerable adults and children. We asked members of medical, nursing and administrative staff about their most recent training .We also looked at training records but they did not identify which staff had received relevant role specific training on safeguarding. After the inspection we received records which confirmed that both GP's were up to date with 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 practice had a system in place for flagging vulnerable patients on their individual records to ensure they were offered appropriate support by staff. This included patients who were at risk of unplanned admission to hospital, at risk children, carers and the housebound.

The practice had posters visible in the reception area and consulting rooms, outlining the availability of a chaperone if required by patients. A formal chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure and is a witness to continuing consent of the procedure.

The practice had a chaperone protocol in place. The protocol was contradictory as it stated that a chaperone must be a member of clinical staff but went on to detail what a non-clinical member of staff should do when chaperoning.

The practice manager told us that the practice nurse and the health care assistant had been trained to be a chaperone. However when we spoke with non-clinical members of staff they told us they performed chaperone duties. Following the inspection we were sent evidence that two non-clinical members of staff had received chaperone training in 2012.

The practice had not carried out checks with the Disclosure and Barring Service for any members of staff or carried out a risk assessment. Therefore they could not be assured that those staff who acted as chaperones were suitable for the role.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and 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.

One member of staff checked the temperature of the fridges within the practice. We looked at the refrigerator temperature records and found that they had not always been recorded daily in line with national guidance to ensure they remained within specified limits. When the member of staff was off duty, for example, September 2014, 11 days, October, nine days, November, 12 days and December 10 days the temperatures had not been recorded. The practice could not demonstrate that the integrity and quality of the medicines were not compromised and it was contrary to the practice's own policy.

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

Data for prescribed medicines for practice within Leicester City was monitored by the Clinical Commissioning Group. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

Practices who were identified as outliers had to complete an action plan of measures to ensure that improvements were made. St Peter's Medical Centre had been an outlier for the prescribing of hypnotics. We spoke with a GP who told us that the practice had taken action. They had reviewed the practices data and now had a policy in place to prescribe alternative medicines.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. For example travel and seasonal influenza vaccinations.

We were told and we saw St Peter's Medical Centre had a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. High risk medicines are prescribed within a Shared Care Protocol with the appropriate secondary care service, for example, rheumatology. Prescriptions are only issued if the monitoring protocol is adhered to. Shared care is a mechanism for sharing patient care between a GP and a local hospital for the prescribing and monitoring of a drug. Effective communication and appointments between the patient, GP and consultant from secondary care.

The practice also had a method on SystmOne to record medicines prescribed by secondary care. SystmOne then had the ability to inform the doctor of any contra-indications of new medicines prescribed by the practice. Appropriate action was taken based on any contra-indications identified.

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.

Cleanliness and infection control

St Peter's Medical Centre was one of two GP practices within St Peter's Health Centre. The contract for cleaning the health centre was the responsibility of a single external company.

We found that the areas used by the practice were mostly clean and tidy. Patients who completed CQC comments cards and staff we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Staff we spoke with told us infection control training was completed on line on a yearly basis.

The practice had a lead for infection control who had undertaken some training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw there were daily cleaning schedules in place. The practice did not carry out spot checks of the areas they used within the health centre to ensure it was kept clean and tidy. We spoke with the management team who told us they would put a process in place.

We spoke with the infection control lead. She told us that St Peter's Medical Centre had not carried out any infection control audits to identify any improvements or actions for the external company who undertake the cleaning in the practice. National guidance states that audits must be undertaken to ensure that key policies and practices are being implemented appropriately.

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. The policy was written by the local commissioning leads for Leicester City and had a review date of November 2014. They provide advice and support related to the quality of Infection prevention and control procedures.

We found that the lead designated in the policy was not the lead identified on the day of the inspection.

We spoke with the management team who advised us that they would ensure the policy is updated and the correct lead is identified.

Sharps bins were correctly assembled and labelled and the practice had a policy for needle stick injury.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Notices about hand hygiene techniques were displayed on the soap dispensers in staff and patient toilets.

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use.

St Peter's Health Centre had arrangements in place for the safe disposal of clinical waste and sharps such as needles and blades. We saw evidence that their disposal was arranged by a suitable external company.

The practice had not taken steps to ensure that legionella risk assessments and water checks were carried out in the areas of St Peter's Health Centre used by the practice. The practice did not have a policy for the management, testing and investigation of legionella. Legionella can be transmitted to people via the inhalation of mist droplets which contain the bacteria. This is the cause of human Legionnaires' disease. The most common sources are water tanks, hot water systems, fountains and showers.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. One member of staff told us that some equipment was shared with the other practice run by Dr Mansingh and Mehra. For example, a spirometer used to measure air in and out of patients lungs. However there should be equipment at both practices as they are registered as separate locations with the Care Quality Commission.

They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitoring and spirometer used for testing the air in and out of patient's lungs.

Staffing and recruitment

We looked at eight staff files which contained evidence that some recruitment checks had been undertaken prior to employment. For example, references, qualifications and registration with the appropriate professional body. However the practice had not undertaken criminal records checks through the Disclosure and Barring Service (DBS) in order to ensure that the practice nurse, health care assistant and non-clinical staff were suitable for some duties where they had contact with patients. There were no risk assessments in place to determine why these were not required. The practice manager told us they would apply for DBS checks on all staff. We saw no evidence in the files of proof of identification, for example, a photograph. The practice had a recruitment policy that set out the standards it followed when recruiting staff. The requirement of photographic identification and DBS checks were not included in the policy.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were enough staff to maintain the efficient running of the practice and there were always enough staff to keep patients safe. Staffing on the day of our visit and records we saw demonstrated that actual staffing levels and skill mix were in line with the planned staffing requirements.

Monitoring safety and responding to risk

St Peter's Health Centre had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the two GP practices and other services within the building. These included annual and monthly checks of the building and the environment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

A health and safety audit had been carried on 23 June 2014 and actions had been identified, for example, each area within the building needed to have their own Control of Substances Hazardous to Health (COSHH) folder and risk assessment. The practice also had a health and safety protocol. The practice manager was identified as the lead for health and safety.

The practice had not taken steps to ensure that risk assessments had been carried out in the areas of St Peter's Health Centre used by practice. They had not ensured that they were aware of any potential risks to patients, staff and visitors and panned any mitigating actions to reduce the possibility of harm. We spoke with the management team who informed us they would carry out the necessary assessments.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed that most staff had received updated training in basic life support.

On the day of the inspection staff told us they did not have oxygen or an automated external defibrillator (used to attempt to restart a person's heart in an emergency) within the practice. However the practice had equipment to maintain a patient's airway in the event of an emergency, for example, oxygen mask and airways. We reviewed the emergency equipment checklist and found that it had not been checked since September 2014.

The registered manager we spoke with told us that St Peter's Health Centre had not allowed them to have an oxygen cylinder in the rooms that they used for the practice. The practice could borrow an oxygen cylinder from another provider located on the first floor of the building. They told us a risk assessment had not been completed to demonstrate how they would keep patients safe in the event of an emergency, for example how they would manage diabetic emergencies. We spoke to the management team and asked them to complete the relevant risk assessment.

Some emergency medicines were available in a secure area of the practice and some staff knew of their location. These

included those for the treatment of anaphylaxis. Anaphylaxis is an acute allergic reaction to an antigen (e.g. a bee sting) to which the body has become hypersensitive. The practice did not routinely hold stocks of medicines for the treatment of diabetic emergencies. They had not carried out a full risk assessment and did not have a protocol in place to manage this emergency. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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

St Peter's Health Centre had carried out a fire risk assessment in November 2013 which included actions required to maintain fire safety. The centre checked the fire equipment, for example, fire extinguishers on a regular basis. We saw a report from the centre's last fire drill in June 2014 in which the evacuation of the whole centre was completed in a timely manner with no problems identified.

Records showed that staff were up to date with fire training. A fire warden had been identified and a fire drill had been carried out by St Peter's Health Centre.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners.

We saw minutes of practice meetings but new guidelines were not disseminated and the implications for the practice's performance and patients were not discussed and required actions agreed. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. 100% of patients discharged had been reviewed.

The practice had well evidenced scoring systems for the treatment and referral of patients to secondary care and other community services. For example, the wells score for the assessment of deep vein thrombosis or the Fracture Risk Assessment Tool (FRAX) which evaluates fracture risks for patients who suffer from osteoporosis.

The GP we spoke with used set templates for referrals within SystmOne. The practice used national standards for the referral of patients with chest pain or suspected cancers. Referrals which arose late in the day were faxed to ensure that they were received in a timely manner.

Referral rates were compared across Leicester City CCG by the use of the Human and Environmental Risk Assessment (HERA) risk stratification tool. HERA supports doctors to detect and prevent unwanted outcomes for patients. Patients are profiled by the allocation of a risk score dependent on the complexity of their disease type or multiple comorbidities. No outlying trends for the practice had been identified by the CCG.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs 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 undertook routine monitoring of chronic diseases as per the Quality and Outcome Framework (QOF). They also did 24 hour blood pressure monitoring and monitored patients who had chronic kidney disease.

The practice showed us six clinical audits that had been undertaken in the last two years. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, patients on medicines for high blood pressure were checked to ensure they were safe following a patient safety alert.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 90% of patients with diabetes had an annual medication review. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The practice had three areas of high risk identified from the Intelligent Monitoring document produced by the CQC. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey.

Good

Are services effective?

(for example, treatment is effective)

We spoke with a GP about the low prevalence of patients with COPD (lung disease) within the practice against expected prevalence. The GP told us that the practice did not have many patients with the disease as smoking within the patient population group was low.

The practice had a 69.9% uptake for cervical screening. Patients who were eligible for screening were invited to attend the practice and those that did not attend were followed up. The GP attributed the low uptake to the ethnicity of the patient population group and a reluctance of the patients to have the screening. Patients are followed up with a phone call and then a letter but the uptake for cervical screening remains low.

The practice did not hold regular multi-disciplinary meetings with community and Macmillan nurses for palliative care patients. However the GP we spoke with told us that palliative care patients have care plans in place and communication is regularly carried out on a case by case basis with the relevant team member. The team members were able to communicate via SystmOne which enabled all communication to be kept electronically.

The team made use of clinical audit tools and joint clinics to assess the performance of clinical staff. The GP we spoke with told us they reflected on the outcomes being achieved and areas where this could be improved.

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 used. 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 GPs 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 GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice comprehensive care plans for patients who were end of life. The care plans were accessible to nurses and carers.

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.

Effective staffing

The practice has one health care assistant and two part time nurses. There is in house training for protocol changes and staff are encouraged to do on line training which is logged. Staff had regular monthly meetings with the practice manager but had not received a formal appraisal. We spoke with the practice manager who told us he would put plans in place to ensure that each member of staff received an appraisal in the next twelve months.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses fire safety, safeguarding adults and children and health and safety awareness. Staff were up to date with basic life support training.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines. Those with extended roles, for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. We looked at the process the practice had in place for blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111

Good

Are services effective?

(for example, treatment is effective)

service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We were told that there was only one instance within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice worked with members of the multidisciplinary team meetings (MDT), for example, midwife, Macmillan nurse, district nurse. MDT meetings did not take place but all members of the team communicate by SystmOne. Staff we spoke with felt information was shared and the system worked well.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 80-90% of 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). Staff reported that this system was easy to use and they checked after four weeks to make sure the patient had received their appointment.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The clinical staff we spoke to understood the key parts of the legislation and were able to give examples of how they implemented it in their practice, for instance in relation to do not attempt resuscitate orders. For situations where capacity to make decisions was an issue for a patient, the practice had drawn up a consent policy to help staff. The policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

When interviewed, GPs and nurse were aware of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. They also 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).

Health promotion and prevention

The practice attended monthly locality meetings with other practices in the Leicester City CCG to address the on-going health needs of the local population.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients over 40 who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Practice data showed that only 23.4% of patients aged 40-74 had received a NHS Health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a

Good

Are services effective?

(for example, treatment is effective)

register of all patients with a learning disability and were offered an annual physical health check. Practice records showed 60.86% had received a check up in the last 12 months.

The practice's performance for cervical smear uptake was 69.9%, which was below average in the CCG area. 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. There was a named nurse 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. Last year's performance for all immunisations was 96% and above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse. There was evidence of signposting young people towards sexual health clinics or offering extra services/ contraception

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 July 2014 national patient survey and a patient survey undertaken by the practice in June 2014.The patient survey over a two week period had only 16 responses and the practice had not extended it in an endeavour to encourage more patients to take part. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the July 2014 national patient survey showed the 81% rated their overall experience as good. 78% found receptionists were helpful. Both these scores were above the CCG average. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice was also above average for its satisfaction scores on consultations with doctors and nurses. 83% of practice respondents said the GP was good at listening to them with 78% for nurses. 76% said the GP gave them enough time and 73% of nurses.

Patients completed CQC comment cards to tell us what they thought about the practice. We received completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a very good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these.

The practice had commenced the Family and Friends testing (FFT) on 1 December 2014. FFT will enable patients to provide feedback on the care and treatment provided by the practice.

We looked at NHS Choices. In 2014 the practice had received two positive and two negative comments. Negative comments with regard to attitude of reception staff and positive comments about how helpful the practice was, praise for all the staff and would recommend the practice to relatives and friends.

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.

The practice reception was a joint reception with another GP practice. We saw that, where possible, staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a sign which informed patients they could request to speak to someone in private and the health centre had identified a room in which patients could use to discuss any confidential issues.

Staff told us that if they had any concerns or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us he would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice behind the patient reception area which stated the health centre's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The July 2014 national GP 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, 82% felt the GP was good at explaining treatment and results and the nurse scored 76%. The results from the July 2014 national patient survey showed that 74% of patients said they were sufficiently involved in making decisions about their care which was above the CCG average. However the nurse scored 61% which was below the CCG average. 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 informing patents this service was available.

We were also told that a number of languages were spoken by staff and this was used to support patients when necessary.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The July 2014 national GP survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88% of patients had confidence in the last GP they saw and nurses scored 83%. However 70% of patients said the GP they saw or spoke to treated them with care and concern. The nurses scored 75%. Both were below the CCG average.

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.

The practice shared a small notice board with another GP practice. The majority of the information related to the other GP practice. We spoke to the practice manager who told us that he would ensure that the board had notices relevant to St Peter's medical centre. The practice did not have a website for patients to access information about the practice or how to access support groups and organisations.

Staff told us that if families had suffered bereavement the GP would be informed. The family would be contacted by letter or by telephone. The 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.

Requires improvement

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 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 locality 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.

On the day of the inspection we looked at the appointment system at the practice. We found they were consistent and had enough appointments to meet the needs of the patients registered with the practice. Patients could book appointments a week in advance and same day appointments were also available.

The practice had a population with a high percentage of patients whose first language was not English. They catered for this by the use of translation services and multilingual staff.

The practice was situated on the ground floor of St Peter's Health Centre. There was lift access to other health care providers on the first second and third floors if required. The practice had wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

There was a large waiting area used by all visitors and patients to St Peter's Health Centre. It was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms in St Peter's Medical Centre. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

Appointments were available from 8.30 am to 6.30 pm on weekdays. The practice closed for lunch between 2 and 3pm but the phone lines remained open. The practice extended opening hours on every evening from 6.30pm until 7pm.

The practice did not have a website and there was no information available in the waiting room to inform patients on how to book urgent appointments and home visits.

The practice had arrangements in place 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.

Longer appointments were available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Home visits were made to local care homes or the housebound by a named GP and 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 and they could see another doctor if there was a wait to see the doctor of their choice. 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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England. However the complaints procedure information which was available to patients contradicted the information within the practice complaints policy. The timescales for making a complaint in the information for patients was incorrect and there was no information to signpost patients to advocacy support to make a complaint. The practice manager was the designated responsible person who handled all complaints in the practice, overseen by a lead GP partner.

Information about the complaints system was not freely available to patients. There was no complaints information

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

displayed in the practice. A complaints procedure leaflet was available to patients once they identified to a staff member that they wished to make a complaint. When we asked a member of staff how patients would be aware of the practice complaints process they showed us a poster in the reception area. The information they identified related to the complaints procedure for another practice which shared the building.

We looked at the practices record of complaints received in the last 12 months. We reviewed seven complaints and found that most had been responded to appropriately and in a timely manner. However one complaint had been received in April 2014 and not been acknowledged or responded to until September 2014. The practice manager told us this had been overlooked due to a transition between one practice manager leaving and another starting. Two complaints had been logged as concerns and not dealt with in line with the complaints procedure or included in the complaints log. There was no process in place to review complaints annually in order to identify themes or trends. It was not clear from minutes of meetings how learning from complaints had been disseminated to staff.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a five year plan which included the recruitment of a further GP, to expand and undertake minor surgery, advanced diabetic care and start heart failure clinics.

We spoke with nine members of staff but they were not aware of the five year plan and did not know what their responsibilities were in relation to these.

Governance arrangements

Governance arrangements for the practice were not robust. There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff. They were all clear about their own roles and responsibilities but were not aware of the five year plan for the practice. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The current governance arrangements had not ensured risk assessments had been carried out in the areas of St Peter's Health Centre used by practice. They had not ensured that they were aware of any potential risks to patients, staff and visitors and planned any mitigating actions to reduce the possibility of harm. We spoke with the management team who informed us they would carry out the necessary assessments. There own governance arrangements have not identified that risk assessments.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on computers within the practice. We looked at 16 of these policies and procedures. All of the policies we looked at had been reviewed annually but some were inaccurate or contradictory of the corresponding procedure, for example, significant event and chaperone policy. The practice manager we spoke with advised us he was on a period of induction to the practice. He told us he would seek guidance from peers and update the policies. He would also ensure that all staff was informed of the updated policies.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed that it had a total score of 90.8% against a national average of 96.4%. We saw that QOF data was regularly discussed at monthly team meetings and but did not see any actions documented on how the practice planned to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, anticoagulation, hypothyroidism and shared care pathways.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least every four to six weeks. 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 had in place a number of human resource policies and procedures. We reviewed a number of policies, for example such as a staff leave policy, a blame free culture policy and the induction policy which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment, sickness and bullying at work. Staff we spoke with were aware of and knew where to find these policies and support if required.

Seeking and acting on feedback from patients, public and staff

The practice had a limited approach to seek out and act upon patient feedback. The practice had undertaken a patient survey in June 2014 but had only had 16 responses. Some of the comments

in the practice survey, for example the phone line being constantly engaged and more time to book an appointment in advance had not been appropriately acted upon.

The practice did not have a patient participation group (PPG) in place. PPG's are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients received. The management team recognised the practice needed a PPG to improve the communication with patients and enable them to be involved in making decisions about their care.

Are services well-led?

Requires improvement

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

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

The practice did not have a website for patients to gain information. However if patients were registered for on-line services they could book, cancel appointments and order repeat prescriptions. NHS Choices also provided patients with information about the practice. The practice had a patient leaflet which did not make reference to NHS choices, on-line services for the practice, policies or health promotion.

The practice did not have a whistleblowing policy in place. Staff we spoke with were aware of how to raise concerns but did not know if the practice had a whistleblowing policy. The practice manager told us he would implement a policy as soon as possible. Whistleblowing is the process by which staff can raise concerns they may have about the practice and the conduct of other members of staff. This enabled concerns raised to be investigated and acted on to help safeguard patients from potentially unsafe or inappropriate care.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. The practice had an appraisal policy in place which stated that all employees would have an annual appraisal and a training needs assessment would be an integral part of this. We looked at six staff files and saw that no formal appraisals had taken place. There were appraisal documents in some files which had been completed by the employee outlining for example what training they felt they required but there was no record of a discussion with an appraiser. Some of the training requested, for example IT training had not taken place. However staff we spoke with said they felt supported by management and could request training informally. The practice manager told us he planned to implement formal appraisals this year.

The practice was a GP training practice and provided GP training for Foundation year two doctors. GP's we spoke with told us the foundation doctors have full support from the practice and all consultations were reviewed by a GP to ensure patient safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not have a robust system in place to manage and learn from significant events and near misses.** **The registered person did not have a system in place to ensure an appropriate standard of cleanliness and infection control, for example, checks on cleaning standards and infection control audits.** **The registered person did not have a system in place to ensure that legionella checks were carried out in the areas used by the practice.** **The registered person had not ensured fridge temperatures were checked daily as per national guidance** **The registered person did not have appropriate arrangements in place to ensure medical equipment was regularly checked as per practice policy** **This was in breach of Regulation 9(1)(b)(ii) and 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (2)(b)(e)(h) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not protected people, or others who may be at risk against the risks of inappropriate or unsafe care and treatment because they did not assess, monitor and mitigate the risks relating to the health, safety and welfare people and others, who may be at risk which arise from the carrying**

This section is primarily information for the provider

Requirement notices

on of the regulated activity. For example, risk assessments for, legionella,oxygen,disclosure and barring service, general office environment, control of substances hazardous to health (COSHH), use of a chaperone and infection control.

The registered person did not have an effective system in place to regularly assess and monitor the quality of the service provided by St Peter's Medical Centre.

The registered person did not have a clear audit programme to improve the quality of patient outcomes.

This was in breach of Regulation 10(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person did not have a robust system in place to manage and learn from complaints. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 16 (2) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purpose of carrying out the regulated activity were appropriately supported in relation to their responsibilities and to an appropriate standard by receiving appropriate training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Requirement notices

This was in breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The registered person did not operate effective recruitment procedures in order to ensure that they employ 'fit and proper' staff who are able to provide care and treatment appropriate to their role and to enable them to provide the regulated activity. This was in breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 and 12 (c) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014)