The Parks Medical Centre - B Hainsworth

Quality Report

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

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Overall summary

The Parks Medical Centre is a GP practice providing primary care services to a population of approximately 4,750 patients in Leicester. There are two partners in the practice. The partners are supported by a locum GP, a practice manager, a practice nurse and two administration/reception staff.

As part of the inspection we talked with the local Clinical Commissioning Group, the local Healthwatch, three representatives of the Patient Participation Group, patients who were at the practice on the day of the inspection, two GPs and other clinical and non-clinical staff at the practice. We also provided comment cards for patients to complete prior to our inspection.

All of the patients we spoke with were very positive about the care and treatment they received and they were complimentary about the staff at the practice. We received positive comments from patients who had completed comment cards prior to our inspection visit. Most of these stated that they were happy with the support, care and treatment provided all staff.

We found that the practice provided a caring, effective, and responsive service to a wide range of patient population groups, including those of working age and recently retired, mothers with babies, young children, and young patients, older patients (over 75), patients with long-term conditions, people in vulnerable circumstances and those patients experiencing mental health problems.

There were child and adult safeguarding policies and procedures in place and systems to ensure that staff were alerted to promptly to any concerns. Protocols were in place in regard to the prescribing of medicines for any patient identified as being at risk due to drug dependency. Prescribing was only undertaken by a GP which allowed them to be alerted to any early repeat medicine requests as this was flagged on the system.

The service was caring with all staff displaying a positive attitude towards patients and their care and treatment.

The care and treatment provided to patients was effective. There was evidence of robust clinical audits taking place to ensure positive outcomes for patients.

We found that the practice was responsive to patients' needs. The practice, along with the support of their Patient Participation Group, enabled patients to voice their views and opinions in relation to the quality of the services they received. Complaints were investigated and responded to and lessons were learned to improve practice.

The management team provided open, inclusive and visible leadership to the staff. Governance arrangements were in place, to continuously improve the practice. Both patients and staff were encouraged and supported to be actively involved in the quality and monitoring of services provided, in order to ensure improvements were made if required.

We found the practice was in breach of the regulations related to:

Management of Medicines

There were some aspects of the way in which the practice was managed that did not support a safe service. We were concerned about the adequacy of checks on medicines and that some medicines had not been stored securely. It was also evident that not all equipment was checked to ensure it was safe to use.

Safety of premises.

Risks to the practice and service provision had not always been appropriately identified and action taken to reduce or remove the risk.

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Improvements were needed to ensure the service is safe.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment.

There were child and adult safeguarding policies and procedures in place and systems to ensure that staff were alerted to promptly to any concerns. The practice had both an emergency and business continuity plan in place.

There were some aspects of the way in which the practice was managed that did not support a safe service. We were concerned about the adequacy of checks on medicines and that some medicines had not been stored securely. It was also evident that not all equipment, such as the eye magnifier, nebulisers and the fridge in the treatment room were checked to ensure they were safe to use. The practice had systems for investigating incidents that occurred but were unable to show how the learning from these incidents was shared with all staff to reduce the risk of reoccurrence.

Are services effective?
The service was effective.

Patients experienced an effective practice. We found that there were processes in place to monitor the delivery of treatment. Clinical audits were used to review and improve outcomes for patients. We noted that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved a total of 99.2%. This was above the average for practices in England. (The QOF audits detail the GP practice achievement results.)

There were processes in place for managing clinical staff performance and professional development. We found the practice had processes in place for multi-disciplinary working, with other health care professionals and partner agencies.

Are services caring?
The service was caring.

Patients experienced a caring practice. We found that patients' needs were assessed, and the care and treatment provided was discussed with patients and delivered to meet their needs. Patients

Summary of findings

spoke positively about their experiences of care and treatment at the practice. Patients' privacy and dignity was respected and protected and their confidential information was managed appropriately. Patients told us that they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Appropriate procedures were in place for patients to provide written and verbal consent to treatment.

Are services responsive to people's needs?
The service was responsive.

We found that the practice was responsive to patients' needs. The practice, along with the support of their Patient Participation Group, enabled patients to voice their views and opinions in relation to the quality of the services they received.

Information about how to complain was made readily available to patients and other people who used the practice (carers, visiting health professionals). Complaints were appropriately investigated and responded to in accordance with the practice's complaints policy.

Are services well-led?
Improvements were needed to ensure the service was well-led.

We found that the management team provided open, inclusive and visible leadership to the staff. Governance arrangements were in place, to continuously improve the practice. To ensure improvements were made, both patients and staff were encouraged to be actively involved in the quality monitoring of the services provided.

Appropriate systems to share best practice guidance, information and changes to policies and procedures to staff were not always robust. Risks to the practice and service provision had not always been appropriately identified and action taken to reduce or remove the risk.

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
We found the practice to be caring in the support it offered to older patients. We saw there were appropriate and effective treatments, along with on going support for patients in this population group. The practice had systems in place to enable it to be responsive to meet the needs of older patients, and to recognise future demands in service provision for this age group.

People with long-term conditions
The practice was caring in the support it offered to patients with long-term conditions and the care provided was effective. Treatment plans were monitored and kept under review by a multi-disciplinary team. The practice was responsive in prioritising urgent care that patients required. The practice was effective in improving outcomes for patients with long-term conditions and complex needs. We saw that the premises were accessible and suitable for patients with reduced mobility and provided enough space for wheelchair users.

Mothers, babies, children and young people
The practice was caring and effective in relation to mothers, babies, children and young patients. The practice offered dedicated clinics to patients in this population group. We saw that referrals to other community based services where made, in order to provide these patients with additional support. The practice had a named GP who specialised in family planning. Systems were in place to ensure that patients who required family planning support, care and treatment, received this effectively and responsively. The practice was responsive in prioritising appointments for mothers with babies and young children. There was a named GP who had overall responsibility for children and adult safeguarding matters. Systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers.

The working-age population and those recently retired
The practice had systems in place to be effective and responsive in meeting the needs of patients in this population group. Extended opening hours had been facilitated to make the practice more accessible to working age patients. People over the age of 40 were offered well man or well woman checks to look for early signs of life long illnesses, or worsening physical or mental health.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care

The practice was caring, effective and responsive in relation to vulnerable patients, who may have poor access to primary care. We saw there were support systems in place for vulnerable patients and the practice was responsive to providing care and treatment at patient's homes, where they had difficulty in attending the practice. We saw that the practice had procedures in place for vulnerable patients to support them to consent to treatment. There was a wide range of services and clinics available to support and meet the needs of this population group.

People experiencing poor mental health

We found the practice had a caring and responsive approach to patients who experienced mental health problems. There were effective procedures in place for undertaking routine mental health assessments of patients in this population group. Appropriate referral systems were in place to provide patient and their carer's on going support with other specialist service.

Effective systems were in place to monitor and assess patients who lacked mental capacity to make informed decisions for themselves. When a patient lacked the capacity to consent, carers were supported to make decisions for patients they held responsibility for. Carers views and opinions were considered when care and treatment was required. The practice management team provided a service that identified and managed risks to patients who experience mental health problems.

Summary of findings

What people who use the service say

We spoke with 14 patients at the practice, received comment cards from a further 11 patients and we

looked at feedback the practice had received through complaints, compliments and the NHS patient survey.

Out of the patients we spoke with or received comments from, all but one expressed high levels of satisfaction with the service provided at the practice, stating they felt respected, listened to and could access a clinician in an emergency situation. All but one also were very positive about the care and treatment they received and they were particularly complimentary about the staff at the practice. We were told by patients that staff were caring, supportive and sensitive to their needs.

Patients told us there was a lot of information available on display and they had received information about their illness or disability in various ways, including in writing and verbally. Patients told us that practice staff answered any queries they may have. They also told us that staff were very respectful, kind and polite at all times.

We spoke with the practices' PPG representatives, who told us they had a supportive, engaging and effective working relationship with the practices' management team. The Patient Participation Group (PPG) is a group of volunteers who work together with the practice to improve services and to promote health and improved quality of care.

Although patients expressed they were satisfied with the service they received, most were not aware that there was a suggestion box or of any other methods they may provide feedback about the service.

The practice provided services to patients with a learning disability who lived in a care home. We spoke with a senior member of staff who supported people living in the care home. They told us they had no problems with the service provided and the practice staff were quick to respond. They also told us a patient had recently had a medicine review and the GP interacted well with the patient during this time. They were aware of how they may raise a complaint if they had any concerns.

Areas for improvement

Action the service MUST take to improve

Medicines must be kept secure at all times and routine checks must take place to ensure medicines are disposed of when not needed.

All portable appliances must be tested in accordance with The Electricity at Work Regulations (1989).

The fire safety risk assessment must be completed and the recommendations acted upon to ensure patients and visitors are protected from the risk of fire.

A legionella risk assessment must take place to identify risks to patients, people and staff. Systems must then be implemented if required, to ensure control measures to reduce the risk of legionella and contamination of water systems are in place.

Action the service SHOULD take to improve

Risk assessments should be undertaken when it has been identified that a staff member has a previous criminal conviction to demonstrate there are no risks to service provision or to patients.

The practice should undertake infection control checks to ensure that all appropriate measures are undertaken to reduce the risk of spread of infection and ensure that appropriate standards are maintained.

The practice should undertake a risk assessment to determine if emergency oxygen should be available on the premises.

The computer system should flag when patients are not requesting their required medicines so this could be investigated or followed up if required.

The practice should consider if any other systems are needed to follow up women who do not attend for their cervical screening.

Further promotion of the Patient Participation Group and their terms of reference should take place to enable patients and members of the public to provide their input into this group.

Summary of findings

Formal systems should be put into place to disseminate lessons learned and action points from significant incidents and complaints.

Formal systems should be put into place to demonstrate that staff meetings took place on a regular basis to assess, review and plan how the practice could continue to meet the needs of patients and any potential demands in the future. Alongside this systems should be improved upon to provide consistent evidence of performance management of staff practices and development.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

Protocols were in place in regard to the prescribing of medicines for any patient identified as being at risk due to drug dependency. Prescribing was only undertaken by a GP which allowed them to be alerted to any early repeat medicine requests as this was flagged on the system.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector; they were supported by two additional CQC inspectors, a GP and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to The Parks Medical Centre - B Hainsworth

The Parks Medical Centre of 340 Aikman Avenue, Leicester, Leicestershire LE3 9PW is a single practice, with no branch surgeries. It provides general practitioner services to a patient population of 4,750. There are two full time GP partners, a locum GP, a practice manager and two support administration/reception staff.

The practice offers an evening surgery on a Wednesday until 8pm for those unable to attend appointments during the day.

The practice offers online services including ordering repeat medication and booking routine appointments. The practice also participates in the Electronic Prescription Service, which allows for repeat prescriptions and increased choice as medication can be collected from other pharmacies if necessary.

The practice has opted out of providing out of hours services to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

The practice serves a mixed age population, a significant proportion of whom are older people. Some patients registered with the practice live in deprived circumstances, and/or experience mental ill health or have alcohol or drug dependencies.

This is the first time this practice has been inspected.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This practice had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Detailed findings

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Healthwatch and local Clinical Commissioning Group to share what they knew about the practice.

We carried out an announced inspection on 10 July 2014. During our inspection we spoke with a range of staff including two GPs, a practice nurse and reception staff as well as the practice manager. We spoke with 14 patients. We also spoke with three representatives from the Patient Participation Group. We reviewed 11 comment cards where patients and members of the public shared their views and experiences of the practice. We observed how patients were being cared for and how they were supported by the reception staff in the waiting area before they were seen by the doctors. We saw how telephone calls from patients were dealt with. We toured the premises and looked at records.

Are services safe?

Our findings

Improvements were needed to ensure the service is safe.

Patients we spoke with and those that completed comment cards said they felt safely cared for and had no concerns about their care or treatment.

There were child and adult safeguarding policies and procedures in place and systems to ensure that staff were alerted to promptly to any concerns. The practice had both an emergency and business continuity plan in place.

There were some aspects of the way in which the practice was managed that did not support a safe service. We were concerned about the adequacy of checks on medicines and that some medicines had not been stored securely. It was also evident that not all equipment, such as the eye magnifier, nebulisers and the fridge in the treatment room were checked to ensure they were safe to use. The practice had systems for investigating incidents that occurred but were unable to show how the learning from these incidents was shared with all staff to reduce the risk of reoccurrence.

Safe Track Record

There was a policy in place indicating what types of incidents would be recorded as significant events and how these would be analysed. Practice staff told us that anyone in the practice could report a significant event. Significant events can be very wide-ranging and can reflect good as well as bad practice.

Systems were in place to disseminate patient safety alerts to all relevant staff, and to ensure that data collected from alerts was monitored, assessed and used to improve patient safety. Patient safety alerts are sent to the practice by the Medicines and Healthcare Products Regulatory Agency (MHRA), the National Patient Safety Agency (NPSA) or the Department of Health.

Learning and improvement from safety incidents

There was a policy in place for significant events which outlined staff's responsibility in respect of reporting, investigating and discussing lessons learned. The policy indicated what types of incidents would be recorded as significant events and how these would be analysed. Practice staff told us that anyone in the practice could report a significant event. We were advised by all staff there was an open and inclusive style of management where staff felt confident to report incidents, significant events and errors.

There was a lack of documentary evidence to demonstrate that lessons learned from incidents/significant events had been discussed. Both GPs told us significant events were subject to a process of root cause analysis and discussed as a practice at monthly or annual meetings to ensure learning took place. A root cause analysis process involved a member of staff at the practice analysing the reasons the event occurred; any actions taken by practice staff and what changes needed to happen to prevent such an incident recurring. However, we found the system was not robust and the practice was unable to formally demonstrate disseminating any learning or action points from significant events to all practice members. The practice manager acknowledged this and stated it would be documented in the future. Sharing learning from incidents is important as it helps to ensure any action required to minimise the risk of reoccurrence is implemented.

We observed that staff were informed of patient safety alerts so they could read them and take any necessary action. Patient safety alerts are sent to the practice by the Medicines and Healthcare Products Regulatory Agency (MHRA), the National Patient Safety Agency (NPSA) or the Department of Health. These notices cover a wide range of topics and help providers learn lessons from each other, and ensure they are aware of risks to the safety of patients so they can take action to minimise these.

Reliable safety systems and processes including safeguarding

The practice had a lead GP designated to oversee safeguarding matters. There was a safeguarding protocol and contact numbers for child and adult protection referrals available. This enabled staff to understand what actions they should take if they witnessed abuse or had a suspicion that this may be taking place. The staff we spoke with had all received child protection and safeguarding vulnerable adults training and they were aware of their roles and responsibilities in respect of their job role.

We observed there was a robust system in place at the practice to flag safeguarding or child protection concerns, which ensured all practice staff were alerted to the potential risks to each patient who may be vulnerable to

harm or abuse. This flagging system was applied to the patient records of all family members to ensure crucial information about early detection/concerns was not missed. The senior partner could demonstrate how details of safeguarding and child protection concerns could be retrieved easily, and all of the staff we spoke with were familiar with the system in place. The system enabled practice staff to be alerted to the risks to vulnerable children and adults, and ensured they had the knowledge and information they needed to ensure these patients were safeguarded from harm or abuse.

Although formal meetings were not held with other multidisciplinary professionals, the GP's told us they used a computerised task system, or contacted them via other methods. This ensured that any necessary information was shared and staff were vigilant and took necessary action, to protect vulnerable adults and children. This also ensured the practice provided information for any safeguarding or child protection strategy meeting if requested.

There was a chaperone policy in place and all staff had been trained in respect of this. If staff knew that a patient needed a chaperone appointment, they would book them in with a nurse and the doctor. All staff who undertook chaperone duties had an enhanced DBS (disclosure and Barring Service) check.

Monitoring safety and responding to risk

The practice had systems and procedures in place for responding to medical emergencies. Staff training records confirmed they had received training in emergency life support so they would know what to do in an emergency. Staff told us they were aware of the emergency procedures to follow. This helped to ensure patients in requiring urgent or emergency medical treatment were appropriately attended to with minimal delay.

Staff were knowledgeable about prioritising appointments to ensure patients were seen according to the urgency of their health care needs. Specific codes were applied to patients who were considered as being at high risk on the computer screen.

There was an automated external defibrillator (AED) available for use in an emergency. Staff spoken with knew where to find the emergency equipment if needed. There was no emergency oxygen available. There was no risk assessment to demonstrate if the use of emergency oxygen should be available on the premises.

We spoke with the member of staff responsible for emergency medicines. We were told there were no emergency medication checks completed. We checked these medicines and found they were in date. Routine checks on emergency medicines would help to ensure these were always available and within the use by date.

The practice did not have a very high population of patients with STI's (sexually transmitted infections), human immunodeficiency virus (HIV) or Hepatitis C. However, there was an alert on the computerised system for anyone who had such infections to ensure staff were aware, and they could take appropriate precautions and support the patient with their individual needs.

Patients we spoke with during our inspection told us they felt safe at the practice. They also told us they felt that the care and treatment they received was safe. These views were supported by the information we received from the comment cards submitted to us.

Medicines management

Vaccines were appropriately stored in medicines fridges where daily temperatures were recorded. Staff were aware of the action to take if fridge temperatures rose above the recommended maximum temperature. This provided assurance that staff would take appropriate action if there were concerns about vaccines in stock, and ensured that refrigerated medicines were stored at the correct temperature. .

There were systems in place for rotating stock and reordering medicines when stock was low. This helped to minimise the risk of patients receiving out of date medicines. We looked at a sample of medicines held in the vaccines fridge and found these were all within their expiry dates. We saw that six patients personal medication was stored within the vaccine fridge. We were told that this was awaiting disposal. However when we checked the dates on these medicines we found that three of these had been in stock for over six months.

We found that the treatment room was not kept locked on the day of our visit. The medicines fridge was stored in this room and also was not kept locked. Medicines were also stored in unlocked cupboards in this room. Patients therefore could have access to this room and the medicines stored in the fridge and the cupboards as they

were not kept secure. We spoke with the practice nurse about this, who told us that the door was normally kept locked and patients did not routinely pass that area unless they were having treatment in that room.

We looked at the way in which medicines and equipment used for medical emergencies were maintained. Single use equipment remained wrapped in its original packaging and was in date. The GP did not carry medicines when undertaking home visits. We were told that the emergency services would be called if required.

We asked to see medication audits or any other records to demonstrate that checks were completed to ensure medicines were managed safely. The practice nurse told us that medicine audits were not completed.

We looked carefully at the management of medicines to make sure these systems were safe and patients were protected from harm. There were no patterns of untoward incidents involving medicines.

We found there were safe systems in place for repeat prescribing at the practice. Each prescription was seen and authorised by a GP, to ensure that repeat prescriptions were not issued for inappropriately long periods of time without being reviewed. Checks were made to ensure that patients on long-term medicines were reviewed on a regular basis.

Protocols were in place in regard to the prescribing of medicines for any patient identified as being at risk. A GP told us that medicines were reviewed every time a patient visited the practice. They outlined the policy in respect of controlled medicines (some prescription medicines are controlled under the Misuse of Drugs legislation. These are called controlled medicines or controlled drugs) and how they followed best practice guidelines to ensure prescribing was safe. Prescribing was only undertaken by a GP, this allowed them to be alerted to any early repeat medicine requests as this was flagged on the system. However it did not flag if patients were not requesting their required medicine so the GP could establish the reason for this.

Cleanliness and infection control

We discussed infection control with the practice nurse and the practice manager. We were told that there had been no infection control checks and no legionella risk assessment undertaken. Systems were not in place to ensure control measures to reduce the risk of legionella and contamination of water systems.

We saw that liquid hand wash and disposable towels had been provided in the public toilets. Information about hand hygiene and the importance of washing hands was on display in public areas.

Clinical/treatment rooms had clinical waste bins, along with liquid soap and disposable paper towels. To ensure strategies were in place to prevent the spread of infection we found that the curtains used in clinical rooms were disposable, and that there was a schedule in place for routinely changing these curtains.

We saw that sharps bins had been dated and information about safe disposable of clinical waste and sharps was displayed. In the consulting rooms we saw that disposable couch rolls were in place, which were changed for each patient. There was personal protective equipment (PPE) available in the clinical rooms.

Cleaning was undertaken by staff employed by the practice and we the practice was clean and tidy with the exception of storage areas. All clinical areas were safe for use. Practice staff told us there were good stocks of PPE and we observed this to be the case.

Patients felt there was a considerable amount of information on safety available to them; however we saw the level of information about aspects such as infection control was limited.

Staffing and recruitment

There were clear policies in place describing how the practice ensured the recruitment of staff was safe. We discussed staff recruitment processes with the practice manager. We were told about the pre-employment checks undertaken. We looked at a random selection of staff files to make sure this system worked in practice, to ensure that the staff were suitable to work with vulnerable adults or children. We found that staff files contained the necessary information and checks.

We saw that a Disclosure and Barring Service check had been completed for all staff. However, we saw that where a previous criminal record had been identified, the service

Are services safe?

had not undertaken a risk assessment to determine there were no risks to service provision, or to the patients from the employment of people who had a previous criminal record.

We spoke with the staff about staffing levels within the practice. They told us there were strategies in place for the clinical team to safely cover staff shortages and absences with minimal or no use of locum or agency staff. There were sufficient staff at the practice and patients did not have any difficulties accessing a GP or nurse appointment. Patients told us they never had to wait for long periods of time, unless they had requested to see a specific GP or nurse.

As the practice was small and very few staff were employed, to ensure there were sufficient staff available to meet patients' needs, each member of staff had various skills to enable them to cover for each other if required. There was a duty doctor system in place to ensure that the practice could provide greater flexibility amongst the GPs to respond to cover absent GPs, busy periods and any emerging risks to patients throughout the day. The practice had secured a locum GP to provide increased access to appointments to ensure patients health and wellbeing was protected.

At the time of our inspection the practice was taking on a significant number of new patients because of local circumstances. They had recognised the need for extra medical staff as a result and were actively recruiting another GP.

Dealing with Emergencies

The practice could evidence appropriate systems and procedures to respond to busy periods (e.g. undertaking open surgeries) and for dealing with medical emergencies in a timely way. The practice were also working with commissioners to look into ways of further reducing A&E attendances safely.

The practice had both an emergency and business continuity plan in place in the event of an emergency situation. This highlighted situations which would present risks to patients and the practice such as computer system failure, telephone breakdown, loss of utilities or floods.

Equipment

We saw that processes and systems to keep the premises and building safe for patients were not always robust. Records of electrical appliance testing (PAT) were seen during our visit. However during our tour of the premises we observed that not all portable/electrical equipment, such as the medicines fridge, the eye magnifier and portable nebulisers had been tested.

The fire safety risk assessment for the practice had not been completed, however we saw that fire fighting equipment had been tested as required, to ensure these would work in the event of an emergency.

There was a planned maintenance plan in use by the practice which took into account accessing further equipment in the event of equipment becoming faulty.

Are services effective?

(for example, treatment is effective)

Our findings

The service was effective.

Patients experienced an effective practice. We found that there were processes in place to monitor the delivery of treatment. Clinical audits were used to review and improve outcomes for patients. We noted that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved a total of 99.2%. This was above the average for practices in England. (The QOF audits detail the GP practice achievement results.)

There were processes in place for managing clinical staff performance and professional development. We found the practice had processes in place for multi-disciplinary working, with other health care professionals and partner agencies.

Effective needs assessment, care & treatment in line with standards

The practice could evidence the use of recognised national guidance and procedures to deliver effective care. We were told by the GPs that patients received care according to national guidelines. We saw that relevant guidelines and national strategies were made available to staff.

Informed consent was obtained for invasive procedures, e.g. minor surgery, and recorded in patients' clinical records. The two GPs interviewed were able to demonstrate awareness and knowledge of relevant best practice and guidance, the Gillick competency (used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge), The Mental Capacity Act 2005 and the Children's Act 2004 to ensure that consent to care was appropriately obtained and recorded.

The Parks Medical Centre is located in a deprived area of the city, where there is a lot of deprivation, poverty and a high than average incident of drug and alcohol dependency. The practice signed up to a substance misuse direct enhanced service to enable them to offer substance misuse clinics on a weekly basis. To ensure patients received care and treatment in line with standards the clinics were led by a substance misuse worker, and an alcohol counsellor from Leicestershire Partnership Trust. The senior GP also attended a substance misuse training course and attended quarterly updates.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We were told by both GPs that they performed their own audits which they used as evidence for their individual appraisal. Examples of clinical audits included, Atrial Fibrillation and peer review for elective admissions to hospital. The practice had effectively been hitting all targets in respect of Atrial Fibrillation and they had signed up to the enhanced service, where they provided diagnosis and on going treatment and monitoring. The senior GP told us that audit results were discussed during clinical meetings and actions agreed with regard to changes to specific treatments and therapies, if required in order to improve outcomes for patients. Clinical staff spoken with confirmed this. However records of these meetings were not always kept to ensure all staff had access to the discussions should they have been absent from these meetings. Therefore the practice was not able to fully evidence how this was shared with all practice members to ensure wider learning for the staff team.

We noted that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved a total of 99.2%. This was above the average for practices in England. (The QOF audits detail the GP practice achievement results.)

Effective Staffing, equipment and facilities

There were policies in place to enable the practice manager and senior partner to assess and manage poor performance should the situation arise. We saw from records and from information shared by staff we spoke with, that there was evidence of performance management and processes in place for managing staff professional development. However we found these were not always undertaken in line with the practices' policies. Although there was evidence of performance management and improvements, this had not been followed through consistently to ensure the appropriate developments had taken place. There was an inconsistent approach to the

Are services effective?

(for example, treatment is effective)

appraisal system, and within two staff files we found that appraisals had not taken place as it had been intended within the staff member's action plan.

We found the last recorded dates for one GP's appraisal was February 2014. When we spoke with the other GP in respect of their appraisals they told us these took place, however they did not keep copies of the information at the practice as they were continually working on these and their development when not at work.

We found there was a training needs analysis for both clinical and non clinical staff. This included a large range of training such as infection control, safeguarding adults and children, fire prevention and customer care. In addition to this we saw examples of specialist training in subjects relevant to the staff member's job role and responsibilities, such as long term conditions and significant events analysis, to ensure staff were supported to develop. Every member of staff undertook specified statutory training in addition to specific training, to ensure they could undertake their role competently.

There was a clear commitment from the practice leadership team to develop the competence of their workforce with a view to improving patient care. The training programme enabled all staff to have some common training, as well as learning and development opportunities which were specific to their role.

Staff we spoke with told us the training available offered them opportunities for continued professional development and to improve their practice.

We found staff had access to the practices policies and procedures and they had signed to state they had read a number of these.

There was a clear policy and system in place to ensure clinical staff were registered and maintained their professional revalidation with their appropriate professional body which the staff we spoke with confirmed was followed in practice. This ensured that clinical staff remained fit to practice.

All of the practice staff told us there was a very low turnover of staff at the practice which meant there was consistency for patients.

Working with other services

The practice did not hold multi-disciplinary meetings to discuss patients with complex and palliative care needs. Information exchange took place via other methods such as computerised systems and telephone calls. These processes ensured that links with other health care professionals such as the palliative care team, health visitor and district nurses remained effective and promoted patients care, welfare and safety.

The practice had signed up to the shared care agreement (some medicines require specific monitoring; therefore the medicine may be subject of shared care agreement guidelines requesting the prescribing to a GP, while the consultant retains overall responsibility for the care of the patient. The agreement identifies each professional's responsibility in regard to the care and agreed channels of communication) and liaised with other multidisciplinary professionals in regard to this. The practice nurse told us that they felt information sharing and liaison with multidisciplinary professionals was good.

Every letter that came into the practice was seen by the GPs. They oversaw the management of blood results and recording information from other health care providers. They looked on a daily basis at information that had been received, logged the information onto the system and took appropriate action.

The out of hours department were not able to access the contemporary/ongoing patient records from the practice. Therefore to ensure they were alerted to any information, if there were concerns, this would be faxed by the GP to the relevant department before the practice closed for the day. The system in place ensured crucial information was shared between services to enable appropriate protection of vulnerable children or adults. This system was also used to flag patients receiving palliative care or those with a DNAR order (do not attempt resuscitation) in place.

Health Promotion & Prevention

We saw that people had access to a range of information leaflets and posters in the waiting room about the practice and promoting good health. Information about how to access other healthcare services was also displayed. This helped patients access the services they needed and promoted their welfare. Health promotion is important because it supports patients to take responsibility for their own health and can help prevent illness in the future.

Are services effective?

(for example, treatment is effective)

The non-clinical administrative staff told us about the processes for informing patients that needed to come back to the practice for further care or treatment. We saw that the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes for example.

The practice had a policy indicating how they would identify and support carers. There was a section on new patient registration forms to enable people to identify themselves as a person providing care for a relative, friend or neighbour.

To ensure health promotion and prevention for those patients who may suffer with substance misuse, they were signposted to sexual health and needle exchange clinics.

The practice offered NHS health checks for patients over the age of 40. NHS health checks assess patients' risk of developing health problems and give personalised advice on how to reduce the risk. Last year the practice exceeded the amount of health checks they needed to complete by 100.

To ensure working women found it easier to access appointments for cervical smears, the practice nurse worked extended hours two days a week. We found that the practice had achieved 85.4% of 100% of their target. To ensure the practice was effective in ensuring women underwent their cervical smear, an initial recall was carried out centrally, if a patient missed this, an alert would be placed on the computerised home page for every patient who had missed and appointment. However there were no other chasing systems in place if patients do not attend for their routine appointment.

New patients underwent a new patient registration process. This gave the patient information about the practice, record keeping and consent. It also gathered information in respect of the patient's individual needs, such as their main spoken language, if they were a carer, the patient's ethnicity and if they had a disability. During this time patients would be assessed which provided an opportunity for a health check and also to offer health promotion advice and information.

If a patient showed signs of memory loss or a family member raised concerns, the GP carried out an assessment to enable early diagnosis of a dementia related illness. Each patient with a complex mental health need had a care plan devised with patients, or their carers and any other professionals involved. This was reviewed and updated annually to ensure patients care and treatment met their individual needs.

As the uptake for immunisations was previously low, additional initiatives and clinics had been implemented to effectively improve the response rates for childhood immunisations. For younger children the rate of uptake was at 99% and for preschool children 90%.

Patients we spoke with were aware of the health checks that were available for them and they confirmed they had attended these when advised. Patients also told us that they felt there was a variety of information available to them in the surgery in respect of different conditions and health promotion information.

Are services caring?

Our findings

The service was caring.

Patients experienced a caring practice. We found that patients' needs were assessed, and the care and treatment provided was discussed with patients and delivered to meet their needs. Patients spoke positively about their experiences of care and treatment at the practice. Patients' privacy and dignity was respected and protected and their confidential information was managed appropriately. Patients told us that they were involved in decision making and had the time and information to make informed decisions about their care and treatment. Appropriate procedures were in place for patients to provide written and verbal consent to treatment.

Respect, Dignity, Compassion & Empathy

The practice had a patient dignity and a chaperone policy. A chaperone can help to provide some protection to patients and clinicians during sensitive examinations. Staff had undertaken chaperone training and the availability of the chaperone service was promoted within the practice to make patients aware that they could request a chaperone if they wished to.

From our tour of the premises we saw notices informing patients that they could ask for a chaperone to be present, during their consultation if they wished to have one. The clinical staff we spoke with demonstrated how they ensured patients privacy and dignity both during consultations and treatments. Examples of this were ensuring that curtains were used in treatment areas to provide privacy, and to ensure that doors to treatment/ consultation rooms were closed.

The majority of patients we spoke with and those who completed comment cards told us that they felt the staff at the practice were polite. Comments from patients were positive in relation to staff and the care and treatment that they received.

We checked to see how the practice maintained patients' privacy and dignity. Patients told us that staff always considered their privacy and dignity and they were aware of the facility to talk in private if they needed.

We found that systems were in place to ensure that patients' privacy and dignity were protected at all times. We saw that the practice had a confidentiality policy in place, which detailed how staff should protect patients. Staff we spoke with, both clinical and non-clinical were aware of their responsibilities in maintaining patient confidentiality. Staff had also received training in information governance as part of their statutory training to ensure staff accessed, used and shared patient information appropriately.

Patients felt confident that information about them and their health and wellbeing was secured appropriately.

As the practice served a population where there was a high number of patients whose first language was not English, we asked staff what interpretation services were in place to facilitate effective communication. Staff told us there were translation services in place which could be accessed at any time to aid communication.

The practice worked closely with the palliative care team as patients approached the end of their life to ensure that collaborative working took place. The GP provided enhanced services which included, control of symptoms, supporting people to die where they choose and with dignity, providing advanced care planning to avoid hospital admission and supporting carers and co-ordinating care. A copy of the care plan would be kept at the patient's home, so everyone was clear about the patient's wishes.

To ensure that other services such as the out- of- hours, the walk in centre or the urgent access centre were aware of patients individual needs, with the patients permission, information could be accessed via the computerised systems or sent to the service via fax. Any special notes would be logged so that other professionals were aware if the patient had a DNAR (Do not attempt resuscitation) order in place. The GP kept DNAR's under constant review to ensure that patients received appropriate care at all times.

The GP also offered bereavement services, signposted or referred patients to other bereavements service if needed.

We did not speak with anyone approaching the end of their life, or providing care to patients in these circumstances, but we did speak with people with life long (and potentially life limiting) conditions who told us the doctors and nurses broke the news to them in a sensitive and caring way.

Are services caring?

Information was available for patients in the reception area, in information packs provided and on the web site which signposted patients and carers to extra help and support.

Involvement in decisions and consent

The practice had knowledge and an understanding of and commitment to vulnerable groups of patients. The practice manager informed us that patients at risk of suicide were given a code on their computer records to show they were at risk. Despite the high number of patients experiencing mental health illnesses, there had not been any cases of suicide at the practice within the last four years. There was a team of psychiatrists that patients could be referred to quickly to support patients if needed. GPs worked with patients and other multidisciplinary professionals to ensure that patients were involved in decisions about their care and treatment.

We looked at how the practice involved patients in the care and treatment they received. We found that patients' involvement in care and treatment was appropriate. We were told by patients that we spoke with that they felt listened to and included in their consultations. They told us

they felt involved in the decision making process in relation to their care and treatment, that GPs and nurses took the time to listen to them, and explained all treatment options.

Patients said they felt they were able to ask questions if they had any. We were told by staff that patients could see the doctor of their choice.

We saw that people had access to a range of information leaflets and posters in the waiting room about the practice and promoting good health.

The practice had procedures in place for patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. We saw from the consent form in use, that there was space on the form to indicate where a patient's carer or parent/guardian had signed on the patient's behalf. Both GP's described how they managed issues with gaining consent from patients who were unable to read or write. The process in place was clear and we were told by the GP that all partners at the practice were aware they should document clearly the reason why written consent had not been obtained and the reason for accepting verbal consent. Both GPs spoken with were able to demonstrate awareness and knowledge of relevant best practice and guidance, for example, the Gillick competency (is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge), The Mental Capacity Act 2005 and the Children's Act 2004 to ensure that consent to care was appropriately obtained and recorded.

We spoke with GPs about how patients who lacked capacity to make decisions and give consent to treatment were managed. They told us that mental capacity assessments were carried out by the doctors and recorded on individual patient records.

Staff had received training in the Mental Capacity Act 2005 and Best Interest Decision making to ensure they had the necessary knowledge and skills to use this in practice.

We overheard reception staff speaking with patients and without exception staff responded to patients in a helpful and respectful manner. Staff tried to resolved issues patients presented with in a way they wanted. Patients we spoke with during our inspection were very complimentary about the staff working at the practice. They expressed that the service they received was of a very high standard and that they couldn't ask for better. This was supported by the information we had received on the comment cards that had been submitted to us.

Most patients felt involved in the planning of their care and they were confident in the treatment they received. They also told us they felt they received sufficient information to enable them to make an informed choice about their treatment options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was responsive.

We found that the practice was responsive to patients' needs. The practice, along with the support of their Patient Participation Group, enabled patients to voice their views and opinions in relation to the quality of the services they received.

Information about how to complain was made readily available to patients and other people who used the practice (carers, visiting health professionals). Complaints were appropriately investigated and responded to in accordance with the practice's complaints policy.

Responding to and meeting people's needs

The patient list of the practice was growing due to local changes in the facilities available. The senior GP had begun to plan for the expected increase in patients and they had discussed this with the Clinical Commissioning Group. The senior GP had taken on a locum doctor and in October 2014 they may look at recruiting a full time salaried GP.

Both GPs' and the practice nurse told us about how patients' needs and potential risks were assessed during initial consultations. They told us that individual clinical and treatment pathways were agreed and recorded on the computerised system. One GP said that individual clinical and treatment pathways were discussed with other healthcare professionals. The multi-disciplinary working ensured that patients received care and treatment from healthcare professionals that were aware of their individual clinical needs and care plans.

Both GPs' described how they discussed with individual patients and carers, which consultant to refer them to based on the patients' needs and preferences. They told us they also used the 'choose and book' method for referrals. We found that the practice was meeting the two week wait requirement for referrals.

Although we could not locate any documentary evidence to support this, we were informed by both GPs' and the practice manager that meetings took place on a regular basis to assess, review and plan how the practice could continue to meet the needs of patients and any potential demands in the future.

The practice had a Patient Participation Group (PPG) and meetings had been conducted to discuss terms of reference and the purpose of the group. Regular meetings took place to ensure patients views and opinions were discussed and considered. We saw that the practice had a website containing a section dedicated to the PPG, where the latest annual report could be accessed by patients and members of the public. Patients' views were listened to and considered in relation to the quality of the services they received. The Patient Participation Group is a group of volunteers who work together with the practice to improve services and to promote health and improved quality of care.

Clinical staff we spoke with told us that there was a wide range of services and clinics available to support and meet the needs of the varied patient groups. They told us they would refer patients to community specialists or clinics, if appropriate. Examples of this were referring older people or their carers to groups who specialised in supporting patients and carers with dementia, and mothers with babies or young children to the health visitor. We were told that the practice did not provide out- of- hours care and this was provided by another service provider, which patients could access via telephone.

Although the practice did not hold meetings with other multidisciplinary professionals, they worked closely with the community nursing team, health visitor and the multi-disciplinary team to ensure the needs of patients were met. We were told by patients that when a referral was required, they were referred promptly.

The practice could evidence the appropriate and timely referral of patients for further care or treatment; all referrals were done by doctors after discussion with patients about choice and options. All test results were screened and actioned by GPs daily as were letters from outside organisations, for example clinic appointments. This ensured they were aware of patient's individual needs and any recommendations or changes in regard to their care and treatment or health and wellbeing.

The practice was located in a deprived area of the city, where there was increased deprivation, poverty, very high incidents of diabetes and lots of young parents and older patients. There was also a high patient population who were dependent upon drugs and/or alcohol. The practice therefore undertook several initiatives to ensure patients individual needs were met. One of these initiatives was that the practice signed up to a substance misuse direct enhanced service. A weekly substance misuse clinic was

Are services responsive to people's needs?

(for example, to feedback?)

held at the practice led by substance misuse worker. In addition to this an alcohol misuse clinic was also held weekly which was led by an alcohol counsellor from Leicestershire Partnership NHS Trust. To achieve this, the senior GP attended a substance misuse training course and attended quarterly updates. Since the commencement of these clinics, further specialist facilities had opened nearby; therefore the practice would cease to run these clinics by September 2014. Arrangements had been made for people who did attend to move across to the new facilities with the GPs taking responsibility for prescribing and long term health management.

The practice had signed up to the shared care agreements (some medicines require specific monitoring, therefore the medicine may be subject of shared care guidelines requesting the prescribing to a GP, while the consultant retains overall responsibility for the care of the patient. The agreement identifies each professional's responsibility in regard to the care and agreed channels of communication). The practice manager told us that they felt communication with other professionals was good.

The practice worked closely with psychiatrists and counsellors to ensure any patient who was dependent upon drugs, received prescriptions in a safe manner and any increases or reductions were discussed between the GP and the patient.

Leicester Clinical Commissioning group had initiatives in place in respect of supporting people who may be homeless. Therefore if someone entered the practice who may be homeless, the person would be registered temporarily so they could receive any treatment of advice they may need.

To support people who may be permanent or temporary travellers in the area, there was a nurse practitioner based near to the practice who provided immunisations for travelling families; the practice directed people to this service of needed.

The practice also liaised with a nearby Sure Start service (the main aim of Sure Start is to offer support to parents from pregnancy and give young children under four from the most disadvantaged areas the best possible start in life. It will aim to promote the physical, intellectual, social and emotional development of pre-school children to ensure they can flourish at home and when they get to school) where health visitors and midwives were based. The practice were taking part in a pilot to bring health visitors back into practice and offered an open clinic on a Thursday morning in addition to age related child health checks.

The practice manager told us that immunisation rates had previously been low so a new imitative had commenced. They now kept a check of all patients who had missed or were overdue their appointments. The practice staff actively called and recalled children three times. For younger children the practice had achieved 99% for preschool vaccines, and were at 90% for older children. Extra clinics were held each day of the six week summer holidays to encourage children and families who needed immunisations to attend. So that people knew about the clinics, target letters and recall letters were also sent out at that time. In addition to this clinic, there was also a set clinic on a weekly basis. The practice manager also told us they had used text message reminders for these clinics with a good effect.

The practice was hitting all targets for supporting patients with atrial fibrillation (AF – is the most common sustained heart rhythm disorder). The practice had signed up to the enhanced services and they provided patients with a diagnosis following various tests. In addition to this they also provided on oing monitoring and tests. To facilitate this there was a lead GP who oversaw the service.

To ensure early diagnosis and detection of breast cancer, screening at the practice commenced at the age of 50 years.

Access to the service

The practice website provided comprehensive information about the clinics and services the practice provided to meet the needs of its patient population. This included clinics which would be routinely available in most practices such as cervical smears, and child vaccinations to ones which were more specialised such as minor surgery.

The practice carried out home visits where needed; these were normally carried out after routine surgery consultations. These visits were reserved for people with disabilities, including those who could not or would not leave their house to attend the practice. This resulted in these appointments being kept for those who were most vulnerable and in need of the service.

Are services responsive to people's needs?

(for example, to feedback?)

From our observations we saw that the premises were accessible for disabled patients, with same level entry into the practice and parking spaces for people with disabilities close to the entrance door. A toilet was available for people with disabilities.

Patients were able to book appointments in advance, by telephone or by turning up at the practice on the day. We looked at the number of appointments each day and same day appointments and ran appointment reports. Although these did not include patients who called and could not been seen, we found that patients were usually given same day appointments or the following day. Priority was given for children under the age of five. We saw this system operating in the practice on the day of our inspection.

At the time of our inspection the practice nurse was not a nurse practitioner; (a nurse practitioner (NP) is a nurse with a graduate degree in advanced practice nursing) however the senior GP was mentoring the member of staff to work towards this qualification in order to increase flexibility of service for patients.

Patients we spoke with told us they did not experience problems when they required urgent or medical emergency appointments. They told us that once they made contact with the practice, staff dealt with these issues promptly and knew how to prioritise appointments for them. The reception staff that we spoke with had a clear understanding of the triage system. This was a system used to prioritise how urgently patients required treatment, or whether the GP would be able to support patients in other ways, such as a telephone consultation or home visit. Patients felt they could get an appointment at the surgery quite easily and there was evidence that that people with long-term conditions and serious health issues could be seen within 24 hours of requesting an appointment.

The GPs and practice staff we interviewed were confident that patients would be seen in an emergency and they used a number of strategies to achieve this cover including; emergency sessions, having a GP on call each day and offering telephone triaging with a GP. We observed these systems in practice and found the staff made every effort to ensure patients who needed to be seen had access to either a GP or a nurse.

There were several systems in place for patients to obtain repeat prescriptions, such as online or by visiting the practice. Patients told us that they had not experienced any difficulty in getting their repeat prescriptions. We were told by staff that they aimed to have repeat prescriptions ready within 48 hours of them being requested by the patient so that they received their prescriptions in a timely manner.

The GPs and other practice staff were aware of the challenges the appointment system presented for working age patients. As a result of this they introduced a number of initiatives to try and improve access for these patients. These initiatives included: extended opening hours on a Tuesday and Wednesday evening. These appointments were pre-booked seven days in advance to reduce the number of patients not attending. These could be done in person, by phone or on line. The practice publicised that these were for working patients. Patients we spoke with commented positively on this improvement and confirmed that it had made it easier for them to access appointments, which accommodated their individual needs.

Concerns & Complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. There was information available to guide patients of the action to take if they wished to raise a complaint, this included information on how to contact the ombudsman. This gave patients the option of taking their complaint further if they were not happy with the way in which the practice responded.

We looked at the records of recent complaints received. Detailed information was recorded including the outcome of the investigation. We saw that the practice responded appropriately to complaints and concerns raised by patients.

We were told that complaints had been discussed at practice meetings; however there were no meeting notes to support this. Although staff told us informal meetings took place, the service were not fully able to demonstrate that complaints were discussed and that lessons were learnt.

Although the practice served a diverse population, we did not see any information on display in the practice that was in an alternative format or language.

Are services well-led?

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

Our findings

The service was well-led.

We found that the management team provided open, inclusive and visible leadership to the staff. Governance arrangements were in place, to continuously improve the practice. To ensure improvements were made, both patients and staff were encouraged to be actively involved in the quality monitoring of the services provided.

Appropriate systems to share best practice guidance, information and changes to policies and procedures to staff were not always robust. Risks to the practice and service provision had not always been appropriately identified and action taken to reduce or remove the risk.

Leadership & Culture

The practice manager and GP partners provided visible, supportive and clear leadership. This was evident from comments from patients, staff, observations in discussion with them. All of the staff we spoke with told us there was an open, transparent and supportive culture at the practice, and an expectation of high standards of service delivery. Staff told us they could ask any question, raise concerns and make suggestions and they would be listened to and responded to. We saw there was a document explaining expected standards of work and behaviour of staff.

The whole practice team had shared visions and values; all staff understood the challenges their patients faced, particularly those in deprived circumstances or in vulnerable situations and they were proud of the work they did to improve the health of their patients. The records we saw and comments from staff and patients showed the GPs advocated strongly for their patients to ensure their health and wellbeing was protected. Interviews with staff and the Patient Participation Group (PPG) indicated the practice manager and GP partners worked collaboratively with others, both internal to the practice and externally to continually improve their service. The Patient Participation Group are a group of patients who work together with the practice staff to represent their interests and views to improve the service provided to them. The staff we spoke with told us that they felt there was an open door culture within the practice, that they felt appropriately supported and were able to approach the senior staff about any concerns they had.

Staff told us that practice and clinical meetings took place. However there was a lack of documentary evidence to support that these took place on a regular basis, to ensure staff were positively encouraged to participate in improving service provision and that information and instructions were communicated by the GPs and practice manager to the staff.

Governance Arrangements

We looked at the governance arrangements in place at the practice and saw that these included the delegation of responsibilities to named GPs, for example, a lead for safeguarding, prescribing and minor surgery. We saw that the lead roles provided structure for staff in knowing who to approach for support and clinical guidance when required.

Staff we spoke with told us there was a clear management structure that included allocations of responsibilities.

The policies and procedures underpinning all areas of the service provided at the practice were up to date and clear. These documents provided guidance for staff who confirmed the documents were accessible to them. However, we found the policies were not always fully implemented in practice, an example being the completion of staff supervisions.

Systems to monitor and improve quality & improvement (leadership)

We looked at the systems in place to monitor and improve the quality of service provision. We found that the performance in the Quality and Outcomes Framework (QOF) report for 2012 to 2013 showed that the practice achieved a total of 99.2%. This was above the average for practices in England. (The QOF audits detail the GP practice achievement results.) The practice used information from QOF audits to further monitor the quality of the services provided to patients. We saw that QOF audit results fed into clinical audits. Whilst we found that clinical audits were effective when they were completed; checks were not routinely carried out to monitor the standards and to identify risks in regard to infection control procedures and records management.

We found that both GPs carried out peer reviews and clinical audit cycles. This supported them in respect of their revalidation and making improvements and developments at the practice. Revalidation is the process by which licensed doctors are required to demonstrate on a regular

Are services well-led?

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

basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC).

We saw that the service had a quality assurance policy with an identified quality assurance lead person.

The practice manager kept a track on the choose and book system on a weekly basis to ensure the practice were meeting the two week appointment wait and also to identify any concerns. They also checked the task list every morning and highlighted any issues with the GP so these could be resolved.

Patient Experience & Involvement

Patient engagement was managed through the Patient Participation Group (PPG) and through comments and complaints raised with the practice manager. The PPG representatives whom we spoke with during our visit told us that the management team were open and responsive to suggestions. They also told us the practice supported regular patient surveys to consider ways to improve the services provided. The Patient Participation Group is a group of volunteers who work together with the practice to improve services and to promote health and improved quality of care.

The PPG had a fundamental role within the practice and they told us they were valued and encouraged by the practice's leadership team, to operate with independence and autonomy in representing the views and interests of patients at the practice. The PPG had put systems in place to obtain patient views, including having personal contact with patients at the practice and within the community and a dedicated section on the practice's website.

We met with three members of the PPG who told us the practice staff listened to them and kept them well informed of events happening at the practice. The senior GP attended the meetings and on occasions external speakers were invited to attend to promote awareness of the expertise in the NHS and health promotion. They also told us that staff at the practice were open to criticism and suggestions and valued feedback from patients and the PPG.

Members of the PPG told us that patients from all population groups were an active part of the PPG to ensure each group actively had a voice.

Information about the PPG and the work they were undertaking was on display within the practice, so patients could see the work they were undertaking and how they may participate in this. Members described their relationship with the practice as positive and that staff were open and honest with them, and they were committed to working to improve the service.

When we spoke with patients, most them were not aware of the practice's website or of any recent improvements that had been made to the service. They did not feel informed about any changes or how they could be involved with the PPG.

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

We saw where comments and suggestions had been raised by the PPG that these had been listened to and acted upon. For example, where changes were required, such as improving appointment waiting times these had been addressed.

We saw where complaints had been received from patients that these had been investigated and responded to appropriately.

A suggestions box was situated in the waiting area to enable people who used the service to leave comments or suggestions. However, no pens, paper or cards were available on which people could leave comments, which presents a barrier to people making suggestions for improvement.

Management lead through learning & improvement

We looked at how the practice learnt from significant events, incidents and training and how these improved services provided to patients. The practice could evidence that investigations had taken place following significant incidents or complaints. However they were unable to fully demonstrate that complaints and significant events were discussed to help staff and the leadership team to learn from untoward incidents by recognising real or potential risks to patients, staff or others and bring about the required improvements or changes.

We discussed audit systems in place. We were told about the clinical audits that took place. However, there was no record keeping audit to ensure that records kept at the service were in good order and up to date.

Are services well-led?

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

Complaints received at the practice had been logged and there was evidence of outcomes recorded. However, the practice manager told us that there was no documentary evidence available to support that complaints were discussed, and that action had been taken and lessons had been learnt to enable the practice staff to bring about any necessary changes or improvements.

Staff told us that training updates provided them with information on current best practice or how improvements could be made.

As there was a lack of minutes the practice were unable to fully evidence how the staff team meetings were used to learn and make improvements, or how patients care, treatment and best practice issues were discussed.

Identification & Management of Risk

The practice did not have robust systems in place to identify and managed the risks to patients associated with the use of equipment and facilities and infection control. We were shown a fire safety risk assessment which was only partially completed. We saw that the risk assessment for the non clinical areas identified that some chairs in the waiting area and drawer handles in the staff room required replacement. The risk assessment also identified that storage cupboards were to be cleared as they presented a fire risk. We were told that the chairs had been replaced as previously the chairs were not resistant to fluids. This had made them difficult to clean because contaminated liquids and fluids could be absorbed into the materials making them a risk for cross contamination. We saw that the handles had been replaced on the cupboards in the staff room. We saw that one storage cupboard had been cleared, however two other storage rooms remained a fire risk as they contained large amounts of stored items such as furniture and records.

There was no legionella risk assessment or infection control risk assessment. Portable appliance testing had been completed on some of the electrical equipment used at the service, but we identified that this did not include all appliances.

Records showed that assessments had been completed in order to consider and determine possible risks to the practice, such as business continuity and disruption, loss of the premises and loss of facilities.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

We found the practice to be caring in the support it offered to older people. There were appropriate and effective treatments, along with on going support for those patients diagnosed with dementia, diabetes and other illnesses. There were no specific clinics held for older people and patients were supported in general clinics. However, the GPs monitored the health, welfare and prescriptions for patients who had a diagnosis of dementia more frequently.

Staff had received training and had an understanding in respect of the Mental Capacity Act 2005 and Deprivation of Liberty to ensure patients' rights and choices were maintained.

The practice worked closely with the palliative care team as patients approached the end of their life to provide enhanced services. Individualised care plans were created and preventative medicines were prescribed if these were needed. The patient also kept a copy of their care plan at their home so everyone was clear about their wishes and needs.

Although professional multidisciplinary meetings were not held, communication took place using other methods to ensure individual clinical and treatment plans were discussed with other relevant professionals and they were aware of their needs.

The practice assessed patients for dementia if they showed any signs of memory loss or a family member raised any concerns.

Home visits were available for those patients who were unable to attend the practice.

The practice was accessible for all patients with parking for people with disabilities; level access and adapted toilets.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

We saw that there were appropriate and effective treatments, along with ongoing support for those patients diagnosed with dementia, diabetes and other illnesses. We were told by the GPs how individual clinical and treatment plans were agreed and recorded. There were systems in place to ensure patients were regularly monitored and provided with information about their condition along with opportunities to improve their health.

Patients with long-term conditions received care and treatment from relevant professionals that were aware of their individual clinical needs. We were told by the GPs and the practice manager that individual clinical and treatment plans were discussed with other healthcare and social care professionals.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The waiting room had several notices boards specifically targeted at this group of patients providing information about family centres, breastfeeding and information directed at teenagers attending the practice.

The practice staff were aware of where patients could receive appropriate service such as those below:

As there is an increasing number of teenage pregnancy and young parents, a service had been commissioned by the CCG to provide sexual health clinics in the town. In addition to this there was a youth centre close to the practice which provided a drop in clinic for children up to the age of 18 years of age for the morning after pill, condoms and sexual health advice.

Family planning services were also provided in the town, information about these were on the practice website or patients were signposted to these services if they attended the practice. One of GPs at the surgery supported patients with the fitting of contraceptive devices.

The practice was taking part in a pilot to bring health visitors back into the GP practice. An open clinic was run on a Thursday morning and in addition to this there were two sessions a week, when baby monitoring clinics took place. Staff at the practice signposted patients to health visitors for breast feeding advice and counselling.

There were breast feeding facilities at the practice and patients were informed of this.

We found that there were child safeguarding policies and procedures in place. Clinical staff were knowledgeable and had received training in safeguarding children. Systems were in place to make appropriate referrals to safeguarding specialists, health visitors and other support providers.

We observed there was a robust system in place at the practice to flag child protection concerns which ensured all practice staff were alerted to the potential risks to each child who may be vulnerable to harm or abuse. This flagging system is applied to the patient records of all family members to ensure crucial information about early concerns was not missed.

The practice ensured that all children under the age of five were guaranteed a same day appointment if they were unwell.

The practice had set clinics for childhood immunisations but in the school summer holidays a clinic was held every day to try and encourage children and families who needed immunisations to attend. Letters were sent to advise people of these clinics. We were told that childhood immunisation clinics were well attended.

We saw that the practice had procedures in place for patients under the age of 16 to consent to treatment.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

People over the age of 40 were offered well man or well woman checks to look for early signs of life long illnesses, or worsening physical or mental health.

The GPs and other practice staff were aware of the challenges the appointment system presented for working age patients, and as a result had introduced a number of initiatives to try and improve access for these patients including telephone triage, telephone appointments and extended opening hours offering pre-bookable appointments two evenings a week. In addition to this the practice nurse had extended working hours until 6:30 pm twice a week to facilitate cervical screening for working women.

The working age patients we spoke with appreciated these developments and told us they could usually get an appointment when they needed one.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice was situated in a deprived area of the city where there was a lot of deprivation and poverty. The practice manager told us that some of their patient population had a dependence on illicit drugs. We spoke with the GPs and we looked carefully at the management of medicines to make sure these systems were safe and patients were protected from harm. There were no patterns of untoward incidents involving medicines. This system was especially robust in respect of controlled drugs (CDs). Controlled drugs are medicines which are subject to extra controls as there is a potential for them to be misused or obtained illegally causing potential harm.

The doctors and nurses working at the practice had a clear insight into the health needs of the patient population and the challenges these presented to both the patient and the practice in maintaining their health wellbeing. Some patients at the practice lived in deprived circumstances and had drug or alcohol dependency and the GPs had a clear understanding of the local organisations available to provide support, advice and treatment for patients with these needs.

We saw there was information available in the waiting area about needle exchange services. This ensured patients who injected illicit drugs were signposted to places where they could obtain clean needles; reducing the risk of acquiring infections which presented significant risks to their health.

The practice signed up to a substance misuse direct enhanced service which enables them to offer a weekly clinic led by a substance misuse worker.

An alcohol misuse clinic was also held once a week which was led by an alcohol counsellor from Leicester Partnership Trust. To enhance this service the senior partner of the practice attended a substance misuse training course and attended quality updates. The practice took responsibility for any prescribing and long term health management for these patients.

The practice worked collaboratively with other professionals to ensure patients received the support they required and information they may have needed.

The Clinical Commissioning Group for Leicester commissions a practice to provide services for homeless people. If a patient who was homeless attended the practice and they needed to be seen they would be registered temporarily at The Parks Medical Centre to enable this.

Although there were no semi-permanent or temporary travellers in the area, there was a nurse practitioner based near to the practice who provided immunisations for travelling families.

There was not a high patient demographic of patients with life limiting Sexually Transmitted Illnesses' such as HIV or Hepatitis C. However, the practice had an alert on the computer system for anyone who had such infections to ensure any appropriate precautions were taken.

The practice supported patients with a learning disability and carried out an annual health check. They also offered support to carers and signposted to them supporting groups if needed.

An interpretation service was available for those patients whose first language was not English.

We saw that there were effective support systems in place for vulnerable people, for example, the practice offered care and treatment in patients' homes, where they had difficulty in attending the practice. We were told by GPs and the practice manager that home visits were conducted for patients who were unable to attend the practice.

We saw that the practice had procedures in place for vulnerable patients to consent to treatment and a form was used to gain the written consent of patients when undergoing specific treatments, for example, minor operations. Both GPs and the practice manager described how they managed issues with gaining consent from patients who were unable to read or write. The process in place was clear and outlined the processes to document

People in vulnerable circumstances who may have poor access to primary care

clearly the reason why written consent had not been obtained and the reason for accepting verbal consent to ensure that consent to care was appropriately obtained and recorded for this particular group of patients.

The practice was accessible for all patients with parking for people with disabilities; level access and adapted toilets.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice staff had an excellent knowledge, understanding of and commitment to this vulnerable group of patients. We saw evidence to show GPs advocated strongly for their patients with other organisations to ensure that those experiencing mental ill health were not placed under undue pressure which may increase feelings of despair or hopelessness and may lead to an increased likelihood of self- harm taking place.

We were told by GPs and the practice manager about how the needs of patients with mental health problems, were assessed during initial consultation. They told us that individual clinical and treatment pathways and care planning were discussed with other mental health care professionals. Each person with complex mental health had a care plan devised with patients, or their carers and any other professional involved. These were reviewed and updated at least annually in line with Care Programme Approach. The Care Programme Approach is a system that is used to organise many people's care from 'secondary mental health services'. This ensured that patients received care and treatment from relevant professionals that were aware of their individual clinical needs and potential risks to their welfare and safety.

Recognised assessment tools to monitor the severity of depression and the patient's response to treatment were used to enable GPs to assess and respond appropriately to risk. Records we saw confirmed that there was careful monitoring of patients' mental health, and referrals were made for specialist support as appropriate to ensure patients received the help; support and treatment they needed to maintain their health and safety.

There was an in-house counsellor who held one session a week if patients required this service. There was also a crisis team that GPs could call to seek additional help and support for patients if a faster response was needed.

We found that a coding system was used to alert staff to high risk patients on the computer screen. All prescribing for medicines was undertaken by a GP and if a patient requested an early prescription the systems alerted them to this. The system did not alert staff if the patient had not requested their medicines.

The practice assessed patients for dementia if they showed any signs of memory loss or a family member raised any concerns.

We spoke with GPs and clinical and non clinical staff about how patients who lacked capacity to make decisions and give consent to treatment were managed. They told us that mental capacity

assessments were carried out by the doctors and recorded on individual patient records. We were told of instances that required further assessment of patients where they lacked capacity. Practice staff had a clear understanding of the requirements of the Mental Capacity Act 2005 and had procedures in place which ensured that patients who lacked capacity were appropriately assessed and referred, where applicable.

We saw a range of information leaflets and posters in the waiting room for people to get information about the practice and about promoting good health. Information about how to access other mental health services and support groups was also displayed.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not always protect patients against the risks associated with the unsafe management of medicines, by means of the making of appropriate arrangements for the recording, safe keeping and disposal of medicines used for the purposes of the regulated activity.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person did not fully protect patients and others who may be at risk against the risk associated with unsafe or unsuitable premises, by means of adequate maintenance and effective systems to identify, assess and manage risks relating to the health, welfare and safety of patients and others who may be at risk from the carrying on of the regulated activity.**