The Practice Bowling Green Street

Quality Report

29-31 Bowling Green Street,
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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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Summary of findings

Overall summary

The Practice Bowling Green Street provides primary medical services for a local population of approximately 2,800 patients. The practice serves a predominantly young population and has a high percentage of migrants. The practice is part of a large corporate provider known as The Practice Surgeries. As part of our inspection we visited, The Practice Bowling Green Street located at 29-31 Bowling Green Street, Leicestershire,LE1 6AS. The practice had no branch surgeries. The staffing establishment consisted of two salaried GP's, a practice nurse, four administrative staff and a practice manager.

We spoke with ten patients including three members of the patient participation group (PPG). PPG's are a way in which patients and GP practices can work together to improve the quality of the service. We spoke with clinical, administrative staff and the practice manager. We also reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

Systems were in place to ensure patients were safe, this included effective safeguarding policies and procedures that were fully understood and acted on by staff.

Audits were effective in changing clinical practice to improve the quality of service and achieve positive outcomes for patients. The PPG had identified areas for improvements that had been escalated to the practice; the response from the practice had not been effective as the issues had not been fully addressed.

Patients were happy with the service that they received. Patients described a caring service where staff would always ask how they felt, and took time to explain their treatment and options.

Aspects of the service were responsive to patients' needs. There was an open culture within the practice and staff felt they were able to raise and discuss any issues with the practice manager. There was a proactive PPG that identified and responded to the needs of patients who used the service.

The day to day management of the practice was well led by the practice manager. The overall quality and governance arrangements were led at a corporate level and there was evidence that the provider had robust systems in place for assessing and managing risks. There were arrangements in place for the provider to disseminate important information to staff so that learning could be applied in practice such as clinical lead meetings and newsletters. However, the arrangements for staff to learn and improve as result of incidents and complaints were less obvious at practice level. We were unable to see evidence of how learning from these incidents were shared with all of the staff to reduce the risk of reoccurrence. There were two GP's working at the practice but only one GP worked full time and was the lead GP. The lead GP's role and responsibility with regards to clinical leadership was not established as this was undertaken at a corporate level.

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?
The service was safe.

There were systems in place to ensure patients received a safe service. There was evidence of regular checks of emergency medicines and equipment and robust systems around the recruitment of new staff. There was information and guidance on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately investigated and addressed. The practice had systems for reporting and investigating incidents that occurred.

Are services effective?
The service was effective.

There was evidence of audits undertaken that were effective in making changes to clinical practice to ensure positive outcomes for patients. We found the practice had joint working arrangements with other health care professionals and services. The GP's and practice nurse had a collaborative approach to working to ensure patients' care and treatment was managed effectively. The practice participation group (PPG) had identified areas for improvement. PPG's are a way in which patients and GP practices can work together to improve the quality of the service. The response from the practice had not been effective as the issues had not been fully addressed.

Are services caring?
The service was caring.

Patients were complimentary about the service that they received and said the GP's at the practice listened to their concerns and were understanding. Patients told us they felt involved in care planning and making decisions about their care and treatment. We found that some of the arrangements at the practice meant that patient's privacy and confidentiality was not always maintained.

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

The practice was accessible to patients with a range of different needs. This included a walk in service, late night surgery and systems in place that ensured patients with mental health needs were reviewed promptly. Patients whose first language was not English did not always have information in different formats and access to interpreting services was not consistent.

Summary of findings

Staff told us that they felt there was an open culture within the practice and felt comfortable to raise and discuss any issues with the practice manager. The patient participation group (PPG) at the practice were responsive in engaging with patients and identifying areas for improvements. PPG's are a way in which patients and GP practices can work together to improve the quality of the service.

Are services well-led?

The service was well-led

The provider had a corporate quality and governance structure in place. There was evidence that the provider had robust systems in place for assessing and managing risks and monitoring the quality of the service. There were arrangements in place for the provider to disseminate important information to staff so that learning could be applied in practice such as clinical lead meetings and newsletters. However, these arrangements for staff to learn and improve as result of incidents and complaints were less obvious at practice level. We were unable to see evidence of how learning from these incidents was shared with all of the staff to reduce the risk of reoccurrence. There were two GP's employed at the practice but only one GP worked full time and was the lead GP. The lead GP's role and responsibility with regards to clinical leadership was not established as this was undertaken at a corporate level.

Summary of findings

The six population groups and what we found

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

Older people
The practice was based in central Leicester and had a lower than average population of older patients. A new programme of care was being implemented for older patients registered at the practice to ensure continuity of care, with the aim to reduce unplanned hospital admissions. Home visits were available for those older patients who were unable to attend the practice.

People with long-term conditions
Patients with long term conditions were reviewed by the GP and practice nurse to assess and monitor their health condition so that any changes could be made. Patients on repeat prescriptions were reviewed to assess their progress and ensure that their medications remained relevant to their health need. here>

Mothers, babies, children and young people
The practice had a weekly midwife clinic and access to health visiting services. Babies and children were offered same day appointments when they were unwell to ensure they were assessed promptly. The GP's undertook six week checks for babies and this was coordinated with the mother's post natal check.

The working-age population and those recently retired
There was a walk and wait service and a late night surgery which was also popular with mainly working age patients. NHS checks were available for people aged between 40 years and 74 years.

People in vulnerable circumstances who may have poor access to primary care
Patients who were vulnerable due to their health or social circumstances were offered health checks. Where appropriate information was shared and referrals made to relevant agencies and health care professionals to ensure their health and wellbeing.

People experiencing poor mental health
There was a high prevalence of patients with mental health needs who were registered at the practice in comparison to the average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning

responsibilities for local health services. The practice had responded to this by joint working arrangements with local mental health services and a dedicated slot each day to review patients with mental health needs.	

Summary of findings

What people who use the service say

We looked at results of the national GP patient survey carried out in 2013. 96 out of 430 surveys were completed and returned. Areas where the practice was doing well in comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG) included waiting times, getting through on the telephone and seeing their preferred GP. A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. There were areas for improvement identified and these supported some of our findings on the day of the inspection. For example only 55% of respondents were satisfied with the level of privacy when speaking to reception staff at the practice. Some of the patients we spoke with told us that the temperature in the practice was hot and uncomfortable and that privacy and confidentiality was not maintained in the waiting area due to its layout.

We spoke with ten patients who used the service, this included three patient participation group (PPG) members. PPG's are a way in which patients and GP surgeries can work together to improve the quality of the service. Most of the patients we spoke with were positive about the service they received. Patients described the practice as caring and told us that they felt involved in their care and treatment. Patients felt the GP listened to their concerns and was understanding. We also sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received thirteen completed cards with positive feedback.

We reviewed comments made on the NHS Choices website to see what feedback patients had given. We saw that although there were some negative comments the practice had responded to all of the comments in a constructive manner.

Areas for improvement

Action the service SHOULD take to improve

Patients whose first language is not English could benefit from the availability of written information in alternative languages and access to interpreting services when needed.

The practice should review how sensitive information is discussed within the waiting area to ensure patients privacy and confidentiality is maintained.

The practice should take action to improve the temperature and ventilation system within the surgery for the comfort of patients, staff and visitors as well as ensuring medicines are kept within the recommended ranges.

The practice should review the system for logging prescriptions so that any anomalies could be easily identified as this would reduce the possibility of misuse of prescriptions.

The provider should consider developing clinical leadership roles and responsibilities for the GP's at the practice. This would enable decisions to be made based on knowledge and understanding of clinical practice at the surgery.

The practice should consider implementing regular fire drills so that staff are prepared in the event of a fire emergency so they are familiar with the procedure.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice had outstanding arrangements for reviewing patients with mental health needs. The last appointment slot of the day was reserved for patients with urgent mental health needs. A 20 minute appointment was given to patients with mental health needs as they often required longer than the standard allocated time.

The Practice Bowling Green Street

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector a second CQC inspector. The team also included a GP and a practice manager.

Background to The Practice Bowling Green Street

The Practice Bowling Green Street is one of 65 member GP practices of Leicester City Clinical Commissioning Group (CCG). It provides primary medical care services to approximately 2,800 patients in the local area. The practice has opted out of out of hours provision, this is provided by an external out of hours service

The practice is run by a large corporate provider The Practice Surgeries. At the time of our inspection the practice employed two salaried GP's but only one GP worked full time.

The practice opened Monday to Friday 08.00 to1830 and offered an evening surgery on Thursdays until 19.30.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider 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?

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 visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We also sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received thirteen completed cards. We carried out an announced visit on 8 July 2014. During our inspection we spoke with a range of staff including clinical and non clinical staff and spoke with patients who used the service and family members. We observed the way the service was delivered but did not observe any aspects of patient care or treatment.

Are services safe?

Our findings

There were systems in place to ensure patients received a safe service. There was evidence of regular checks of emergency medicines and equipment and robust systems around the recruitment of new staff. There was information and guidance on local reporting arrangements for safeguarding children and vulnerable adults so that any concerns could be appropriately investigated and addressed. The practice had systems for reporting and investigating incidents that occurred.

Safe patient care

We saw that the practice had a computerised incident reporting system which allowed for themes and trends to be identified and acted on. We saw that there had been a number of patient behaviour incidents that staff had reported such as threatening behaviour. This also reflected a trend that had been identified corporately. We saw that as a result of this, the provider had developed an action plan which identified training for staff.

Systems were in place to audit infection prevention and control practices and act on patient safety alerts which were issued when potentially harmful situations are identified and need to be acted on.

Learning from incidents

Staff told us of an open culture where management was approachable. There was evidence that staff were reporting incidents and these had been recorded on a log. We saw that most of the incidents reported by staff were not significant in nature. It was apparent from our discussion with staff that there was a lack of clarity on what constituted a significant event. For example incidents that related to staff being late due to difficulties parking .Significant events should be prioritised on the basis of their actual, or potential, consequences for the quality and safety of patient care. There should also be clear opportunities for learning and improvements to take place as a result of incidents that had occurred. We identified that 'significant events' were shared with clinical staff in meetings that did not include non clinical staff. This meant that that there was no formal system for discussing incidents and any learning with non clinical staff at the practice.

Safeguarding

There were clear safeguarding policies and procedures for staff to respond to any concerns. Staff we spoke with were able to demonstrate knowledge and awareness of safeguarding vulnerable adults and children and were clear and confident they would recognise and respond to any concerns. Staff were aware of the role of the safeguarding lead GP and said they would refer to them for advice and guidance.

The practice had a safeguarding vulnerable adults and children policy in place. Staff had access to current guidance and contact numbers for local safeguarding teams to refer to and support them in the identification and reporting of safeguarding concerns. We saw that the practice had a whistle blowing policy and staff told us that they felt confident to raise any concerns about poor care that could compromise patient safety. Whistleblowing is when staff are able to report suspected wrongdoing at work, this is officially referred to 'making a disclosure in the public interest'. Patients spoken with did not report any safety concerns to us.

All of the staff had attended training in safeguarding children and vulnerable adults. The GP with the lead role for safeguarding had completed level 3 training. This level of safeguarding children's training helps develop knowledge, skills and the ability to work collaboratively on the processes for safeguarding and promoting the welfare of children. We saw evidence of a safeguarding referral made, as a result of concerns, in line with safeguarding procedures.

There were systems in place to alert staff to safeguarding concerns and evidence that safeguarding issues were discussed during staff meetings. There were no formal meetings with health care professionals such as health visitors and midwifes although there were systems in place to share information of concern.

Monitoring safety and responding to risk

A fire risk and health and safety risk assessment was in place which gave a clear picture of potential risks and how these were to be reduced. There had been no recent fire drills at the practice. Regular fire drills would ensure staff were familiar with the fire procedure.

There was evidence that regular health and safety checks were done to ensure the safety and suitability of the general environment.

Are services safe?

There were arrangements to deal with foreseeable emergencies. Staff had received training in responding to a medical emergency and there were emergency medicines and equipment available so that staff could respond safely in the event of a medical emergency. The practice had an emergency medicines trolley which included oxygen and an automated external defibrillator (AED). This equipment is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present.

Medicines management

During this inspection we discussed with a practice nurse the system in place for checking emergency medicines. A list recorded all of the emergency medicines that were available. We noted that a medicine that could be used in the event of suspected bacterial meningitis although available was not on the list and was stored in a separate location. This could result in staff being unaware of its availability. We discussed this with the practice manager at the time of our inspection who told us that they would address the issue. We checked a sample of the available medicines and saw that they were all in date. There was evidence that the emergency medicines and oxygen were checked regularly to ensure they were available when needed and were safe and effective to use in the event of a medical emergency. We saw that the emergency medicines were stored securely and accessible to staff. We noted that information on most of the medicines stated that they should not be stored above a specified temperature range. Staff confirmed that there was no system in place to monitor the temperature of the environment so that they could be confident that the medicines were stored within the recommended range.

There was a dedicated secure fridge where vaccines were stored. There was evidence that regular checks of the fridge temperature were undertaken and recorded to provide assurance that the vaccines were stored within the recommended range and were safe and effective to use. We noticed that on one occasion the recordings showed that the fridge temperature had exceeded the recommended range and it was not clear what action was taken. Staff that we spoke with were able to provide an explanation for the incident. A lack of documentation of the actions could result in uncertainty on what, if any action had been taken.

We saw that prescriptions were stored appropriately to reduce the likelihood of misuse. There was no logging system for prescriptions such as the recording of the serial number of the prescriptions so that any anomalies could be easily identified.

Patients on repeat prescriptions were invited for reviews to assess their progress and ensure that their medications remained relevant to their health need.

Cleanliness and infection control

The practice was visibly clean and tidy. There was availability of personal protective equipment (PPE) for staff and systems in place to reduce the risk of cross infection such as colour coded cleaning equipment. Staff had received training in infection prevention and control and our discussion with staff further demonstrated their knowledge and awareness. We saw that the provider had a clinical waste contract to ensure the safe disposal of clinical waste. An infection control policy was in place to guide staff and ensure staff adhered to good practice and an audit had taken place to monitor standards. We saw that there was a cleaning schedule in place which included a daily, weekly and monthly schedule. However, the schedule had not been completed this did not provide good evidence to demonstrate that the environment was regularly and consistently cleaned to a high standard.

Staffing and recruitment

The practice had a relatively small patient list size. The staffing establishment consisted of two salaried GP's only one of whom was full time, a practice nurse, four administrative staff and the practice manager. The practice nurse had recently been appointed and worked in conjunction with GP's to manage patients with chronic diseases. The practice nurse also had responsibility in areas such as childhood immunisations, travel vaccinations and cytology.

We saw that there were arrangements in place to plan ahead when the GP's were on annual leave to help ensure that there was sufficient GP cover to see patients.

The provider operated safe recruitment procedures. There was evidence that appropriate pre-employment checks were completed, which included proof of identity and reference checks. All of the staff employed at the practice

Are services safe?

had a Disclosure and Barring Service (DBS) check. The DBS check replaced the Criminal Records Bureau (CRB) check and helps identify people who are unsuitable to work with children and vulnerable adults.

All of the GP's employed at the practice included locum GP's were part of the local NHS Medical 'Performers List'. Locum GP's are not employed by the practice and work on an as required basis, they are usually provided through an agency. Any doctor who wishes to perform general medical services (GMS) must be on a performers list. All of the GP's also had up to date professional indemnity insurance. This insurance provides compensation payable to patients in the event of an error or omission by the locum GP.

There were systems in place to monitor and review staffing levels to ensure any shortages were addressed and did not impact on the delivery of the service. The practice employed two permanent salaried GP's, one of whom worked full time. Any shortfalls were covered by locum GP's. Nursing cover was provided when needed by staff from another of the provider's practices.

Dealing with Emergencies

The practice had a business continuity plan which covered a range of areas of potential risks relating to foreseeable emergencies and events and how these risks could be mitigated to reduce the impact on the delivery of the service.

Equipment

There was evidence that portable appliances used in the practice had been tested. This meant that they had been checked to ensure they were in good working order and safe to use. Equipment used in the event of a fire and medical emergency had also been checked and tested to ensure they were fit for purpose.

Are services effective?

(for example, treatment is effective)

Our findings

There was evidence of audits undertaken that were effective in making changes to clinical practice to ensure positive outcomes for patients. We found the practice had joint working arrangements with other health care professionals and services. The GP's and practice nurse had a collaborative approach to working to ensure patients' care and treatment was managed effectively. The practice participation group (PPG) had identified areas for improvement. PPG's are a way in which patients and GP practices can work together to improve the quality of the service. The response from the practice had not been effective as the issues had not been fully addressed.

Promoting best practice

We saw that meetings took place for clinical staff which provided a forum for discussing clinical issued including how best practice could be implemented and ensuring practice reflected national guidance. Best practice guidelines for antibiotic prescribing had been implemented as a response to data that showed high prescribing rates. Other areas of best practice included prescribing of NSAID (Non-steroidal anti-inflammatory drugs) and auditing the overall management of medicines to ensure the arrangements in place reflected best practice.

Management, monitoring and improving outcomes for people

The practice carried out reviews as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards surgeries achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. Data that we reviewed showed that in some areas the practice was performing lower than average in comparison to other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services. In the year 2013-14 the practice performance for childhood Immunisation and vaccination score was 84.96% compared to the CCG score of 94.60%. There was evidence that performance was monitored through the year by the practice manager and action taken accordingly. For example we saw that data from QOF was used to target patients who required reviews of their health conditions. This included a dedicated clinic to review patients. The practice recently identified patients who had outstanding vaccinations and a letter was sent inviting them to the clinic.

The practice had a high prescribing rate for a specific medication. This was reviewed by the lead GP and it was found that the prescribing reflected the high number of patients at the practice with mental health needs. A practice protocol was implemented to ensure consistency in practice.

There was evidence that the high number of referrals to outpatient services had been reviewed and a completed audit cycle had resulted in changes to clinical practice.

The practice participation group (PPG) had identified in November 2013 that the ventilation system in the surgery required improvement. PPG's are a way in which patients and GP surgeries can work together to improve the quality of the service. However, to date there had not been an effective response from the practice as the issue had not been fully addressed.

Staffing

Clinical staff received formal supervision sessions and appraisal which were undertaken by the corporate clinical leads. Administrative staff did not have regular supervisions sessions although there was evidence of annual appraisals to support staff with their ongoing professional development.

Staff had received training in core areas such as basic life support, fire awareness and safeguarding vulnerable adults and children. Staff training was recorded on a training matrix which provided a system to monitor staff training needs. We saw that some staff were due refresher training in areas such as infection prevention and control and fire awareness, some of the clinical staff last had this training in the year 2011. Training updates would ensure staff knowledge and skills remain current and reflect best practice.

Working with other services

We found the practice had joint working arrangements with a local mental health service called Improving Access to Physiological Therapies (IAPT). The service supported patients with mental health needs. We spoke with the IAPT practitioner who was employed by Leicester Partnership Trust (LPT). They told us that they were based at the

Are services effective?

(for example, treatment is effective)

practice one day a week as they regularly received referrals from the practice. The IAPT practitioner told us that they would liaise with the GP around a medication regime (where appropriate).

The midwife held a weekly clinic at the practice to review patients who were pregnant and this provided an opportunity for practice staff to work collaboratively.

The clinical staff provided examples of how they worked with other services and professionals for example where there were safeguarding concerns although there were no regular formal information sharing meetings.

The practice had opted out of providing out of hour's services. This had been contracted by the CCG to an external out of hour's service provider.

Health, promotion and prevention

There was information in the practice leaflet that showed the various nurse led clinics provided at the practice. These included health and travel advice, smoking cessation, blood pressure monitoring and cervical smears. These clinics provided patients with the information they needed to maintain good health.

There were systems in place to ensure patients received a review of their medicines which were undertaken by the GP's. This would ensure patient's medications remained relevant to their health needs and any changes could be made as needed.

Are services caring?

Our findings

Patients were complimentary about the service that they received and said the GP's at the practice listened to their concerns and were understanding. Patients told us they felt involved in care planning and making decisions about their care and treatment. We found that some of the arrangements at the practice meant that patient's privacy and confidentiality was not always maintained.

Respect, dignity, compassion and empathy

We looked at results of the national GP patient survey carried out in 2013. 96 out of 430 surveys were completed and returned. There were areas where the practice was doing well in comparison to the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs. There were also areas where the practice was below the regional average for other practices in the local CCG. For example 68% of respondents said that the last GP they saw or spoke to was good at treating them with care and concern. As part of the inspection we sent the practice a box with comment cards so that patients had the opportunity to give us feedback. We received thirteen completed cards. They all gave very positive comments about the practice. Patients spoken with on the day of the inspection gave examples of where they felt they were treated in a caring, compassionate manner. One patient felt that the GP listened to their concerns and was understanding.

We asked staff about bereavement support for patients. They told us they would signpost patients to Bereavement Cruise (a bereavement support group). The patient's name and details would be passed on with their consent so that the patient could be contacted to discuss their support needs. Staff told us the process was very quick and the service was based near the practice in Leicester city centre. One patient told us about their experience of receiving support following bereavement, they talked about GP's that were very helpful and who went above and beyond for their patients.

We spoke with one patient who had been referred to counselling facilities and was pleased that the GP had identified their need for emotional support. We saw information displayed in the practice waiting area that promoted a range of support groups such as Open Mind, First Step, and the Domestic Abuse Disclosure Scheme.

We saw the storage facilities for patient records ensured that they were held securely and remained confidential. We found from our observations whilst sitting in the patients' waiting area that confidentiality was not always maintained. Patients could be overheard in the waiting area when they checked in at the reception desk, even when they were speaking quietly. We heard reception staff speaking on the telephone following up individual patient's care and treatment, which included confidential information. Our discussion with PPG members established that this had been identified as requiring improvement, however no action had yet been taken to address the issue. One patient told us the waiting area did not allow for private conversations. Staff showed us a quiet area to speak in confidence with patients however, it was in a communal corridor that was a thoroughfare. There were no signs or information available to promote this area to patients. The quiet area did not provide sufficient facilities for private discussion.

We saw information displayed on notice boards advising patients about the availability of chaperones. Three reception staff had received chaperone training. The practice manager confirmed further training was being arranged for existing and new staff. We heard a receptionist confirm with a patient that a chaperone would be made available for their consultation with the GP.

We saw privacy curtains were available in treatment rooms; and patients confirmed curtains were used during physical examinations to ensure their privacy and dignity.

A closed circuit television system (CCTV) was in operation inside the premises in the communal areas such as the waiting room. We saw there were signs on display informing patients of this although the signs did not state why CCTV was in operation. This information helps patients to understand the purpose of the cameras such as staff safety, or crime prevention reasons. It was also apparent that the CCTV system was shared by another service based in the building which could impact on patient privacy and confidentiality. The practice manager agreed to obtain appropriate signs and explore the shared CCTV arrangements.

Involvement in decisions and consent

We saw written information in the waiting area. The information included details of advocates, groups and agencies to contact should patients require advice and support. Patients told us they felt involved in planning their

Are services caring?

care and making decisions. One patient told us that a GP at the practice had listened and understood their needs, and they had been referred to an appropriate service. Another patient told us the GP would always ask how they felt, and took time to explain their treatment and options which made them feel involved and informed about their care. Patients told us that staff always provided clear explanation about any tests or treatment, the reason for these, and why they were being done. Patients told us that they gave informed consent to any care and treatment that they received.

The demographics of the patient population showed that the patient group was 48% black and minority ethnic and included a high migrant group with a wide variation in languages spoken. We found there was no written information displayed in different languages and formats. One patient who we spoke with told us that their relative needed to see the GP and did not speak English and they were concerned about this. They felt they would have to go to a private GP that spoke their community language.

Some reception staff told us they were able to speak other languages and where appropriate they would use their language skills to welcome and greet patients. Staff told us they regularly used language line (a telephone translation services for patient consultations). Staff explained the common requests for translation services were for Polish, Mandarin and Chinese languages. However, they explained the challenges of using language line. We found that this had impacted on the use of language lines. Instead of using language line for interpreting, staff were told to ask patients to bring a second person such as a relative to assist with communication during their consultation. We discussed this with the practice manager as it would not always be appropriate to bring a relative or friend as it may prevent the patient discussing sensitive issues in confidence, they agreed to look into the issue further .Providing interpreting services and information in accessible formats would ensure patients had access to information to support their involvement and consent.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was accessible to patients with a range of different needs. This included a walk in service, late night surgery and systems in place that ensured patients with mental health needs were reviewed promptly. Patients whose first language was not English did not always have information in different formats and access to interpreting services was not consistent.

Staff told us that they felt there was an open culture within the practice and felt comfortable to raise and discuss any issues with the practice manager. The patient participation group (PPG) at the practice were responsive in engaging with patients and identifying areas for improvements. PPG's are a way in which patients and GP practices can work together to improve the quality of the service.

Responding to and meeting people's needs

The practice had a high number of patients who attended Accident and & Emergency (A&E) compared to the national average. The prevalence of patients with mental health needs was high at the practice and this group of patients had been had identified as presenting in A&E more frequently. A dedicated slot had been introduced to reduce the number of unnecessary Accident and & Emergency (A&E) admissions by patients experiencing mental health difficulties. The practice worked collaboratively with health care professionals from the local mental health service IAPT (Improving Access to Physiological Therapies) who undertook clinics at the surgery for registered patients experiencing poor mental health.

The practice carried out reviews of patients as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards surgeries achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. This included a dedicated clinic to review patients. The practice had recently identified patients who had outstanding vaccinations and a letter was sent inviting the patients to the clinic. Patients with a learning disability were offered annual health checks.

The GP's and practice nurse had a collaborative approach to working to ensure patients' care and treatment was managed effectively.

Staff told us sometimes they had to respond patients who may display aggression. They told us that they would report these incidents to the practice manager for review and action. We saw that this was a risk that had also been identified by the provider and actions had been identified which included staff training. The provider had a policy in place for the prevention and management of violence and aggression at the workplace to provide some guidance to staff.

We saw that the practice had an active and engaged patient participation group (PPG). PPG's are a way in which patients and GP surgeries can work together to improve the quality of the service There was evidence that the PPG group had consulted with patients on the feedback from the patient satisfaction surveys. The PPG had identified and responded to areas of improvements such as the lack of adequate temperature control in the building and patient confidentiality in the waiting area. The PPG also identified that membership of the PPG did not fully represent the practice population. They responded to this by external engagement with local groups to recruit new members.

There were no female GP's working at the practice. This meant that patients may not have a choice of receiving gender specific care and treatment. We saw that there were some arrangements in place which included where appropriate patients having the option of seeing the practice nurse, a chaperone service and referring patients to other primary care services.

Access to the service

Staff confirmed a range of appointments were available to meet the different needs of patients. There was a walk and wait service and a late night surgery which was also popular with mainly working age patients. A slot was allocated each day to review patients with urgent needs.

To meet the needs of patients who have restricted mobility and may require the use of a wheelchair there was wheelchair access to all areas within the building and a lift to access all floors.

The practice had a high number of patients whose first language was not English. An alert system was in place which highlighted patients who required an interpreter booking through 'language line' so that this was identified before their consultation and the interpreting service could be booked in advance. However, we identified that the use of the interpreting service was not consistent. This was

Are services responsive to people's needs?

(for example, to feedback?)

because instead of using language line for interpreting, staff were told to ask patients to bring a second person such as a relative to assist with communication during their consultation.

Concerns and complaints

The practice had a formal complaints procedure in place. The practice leaflet made reference to raising concerns and complaints with staff or referring to the 'patient's complaints guidance poster' available in reception. However, we did not see and staff confirmed that no posters were on display. The practice manager was unable to give examples of complaints that had led to a change in practice. We saw that all of the recent complaints received related to patients asking for access to medicines inappropriately. We saw that the practice had a whistleblowing policy in place. Staff talked about an open culture where they were confident to raise any issues. There was evidence that complaints across the provider's service were reviewed as part of an annual report, findings were shared with staff through newsletters and included case studies to support staff learning.

We looked at the NHS Choices website to see what feedback patients had given. We saw that there was some negative feedback however, the practice had responded to all of the comments in a constructive manner. The practice also actively encouraged patients to get in touch so that any issues could be discussed further.

Are services well-led?

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

Our findings

The provider had a corporate quality and governance structure in place. There was evidence that the provider had robust systems in place for assessing and managing risks and monitoring the quality of the service. There were arrangements in place for the provider to disseminate important information to staff so that learning could be applied in practice such as clinical lead meetings and newsletters. However, these arrangements for staff to learn and improve as result of incidents and complaints were less obvious at practice level. We were unable to see evidence of how learning from these incidents was shared with all of the staff to reduce the risk of reoccurrence. There were two GP's employed at the practice but only one GP worked full time and was the lead GP. The lead GP's role and responsibility with regards to clinical leadership was not established as this was undertaken at a corporate level.

Leadership and culture

Staff and patient participation group (PPG) members were positive about the practice manager who they felt was approachable, supportive and willing to listen to feedback. PPG's are a way in which patients and GP surgeries can work together to improve the quality of the service. Staff spoke of an open culture where they were confident to raise any concerns. There was evidence that provider shared information and learning with staff in newsletters that were circulated on a weekly basis. This included the annual report on incidents, complaints and risks across the provider. Staff were encouraged to report incidents and complaints to improve the quality of the service. This showed a culture where transparency and openness was encouraged.

Governance arrangements

As the practice was part of a corporate provider the clinical governance arrangements at the practice were led at a corporate level. Our discussions with the lead GP at the practice confirmed that the clinical lead role was undertaken at corporate level. The clinical lead was not involved in the day to day management of patients care at the practice and did not attend the clinical meetings although there were arrangements in place for the clinical lead to meet with the GP lead.

We were provided evidence that showed the provider's clinical governance framework. The provider had a Governance Committee, and a Clinical Board which met regularly. At each meeting the monthly clinical governance report which covered all of the provider's services was reviewed. An analysis of complaints and incidents across all of the provider's services was undertaken to establish themes and trends so that these could be acted on.

Systems to monitor and improve quality and improvement

Examples of regular audits undertaken at provider level included appointment availability, prescribing audits and complaints. The practice had also undertaken audits in areas such as prescribing, infection prevention and control, attendances to Accident and Emergency departments and referral to secondary services. There was evidence of improvements made as a result of findings such as reduced rates of prescribing. The practice manager completed monthly management reports to head office which included a range of areas such as whether staff and participation group (PPG) meetings took place. PPG's are a way in which patients and GP surgeries can work together to improve the quality of the service. This enabled the provider to review the practice performance in these areas.

Patient experience and involvement

Results for the practice from the national GP patient survey carried out in 2013 were mostly outside the regional average for other practices in the local Clinical Commissioning Group (CCG). A CCG is an NHS organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services range with areas for improvement identified. For example 69% of respondents described their experience of making an appointment as good There was evidence that the practice was engaging with patients to obtain their views about their experience of care and treatment. The practice carried out a monthly patient experience survey that were sent to head office. There was evidence that results of patient satisfaction surveys were discussed at PPG meetings. The PPG was proactive in their approach and demonstrated a genuine interest about improving the quality of the service for patients. There was evidence that the PPG was reaching out to hard to reach groups so that the PPG membership reflected the patient population.

Staff engagement and involvement

The provider gave feedback to staff through weekly newsletters. Information sharing arrangements at practice level were less clear. We were told that that issues such as

Are services well-led?

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

complaints, incidents and significant events were discussed at staff meetings. Some of the staff told us that information was shared on an informal basis. We saw that significant events were discussed with clinical staff in meetings that were not attended by non clinical staff. We found that some of the staff meeting minutes lacked detail as to the discussion that had taken place. This did not provide robust evidence and assurance that important information had been disseminated to staff.

Regular staff meetings took place for administrative and clinical staff. There was evidence that as a result of staff feedback changes had been made. This included an alert system for patients whose first language was not English and ensuring safeguarding information was available to staff.

The provider's weekly newsletter provided the opportunity to celebrate staff achievements.

Identification and management of risk

We saw that the provider had a formal process to support clinical governance. This included incidents and complaints management and reporting. A report on incidents and complaints was produced every year so the provider could establish themes, trends and manage risks. The practice manager had completed a fire and health and safety risk assessment to establish any potential risks and how these could be minimised. Risks across the provider were shared with staff as part of weekly newsletters and showed how the provider was identifying and minimising risks.

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

The demographics of the practice meant that there were few older patients registered at the practice. At the time of our inspection there were only 16 patients who were over the age of 75 years.

In response to reducing unplanned hospital admissions for at risk patient groups such as older patients registered at the practice, a new programme of care was being implemented. This meant that older patients were allocated a named GP so that the GP would have overall responsibility for their care at the practice. This would ensure that the GP became familiar with their individual health needs and the patient's care would be more coordinated. A care plan would be put in place to ensure the patients health needs including long term conditions were managed effectively. The aim was for patients to be reviewed at least every three months once the care plan was in place.

There were arrangements in place to review patients who were unable to attend the practice. A triage system was in place to assess patients who required a home visit. We saw that on average the GP completed one home visit each week.

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

There was evidence of a collaborative approach with the GP and nurse to managing and reviewing patients with chronic disease.

The practice carried out reviews of patients with long term conditions as part of the Quality and Outcomes Framework (QOF). The QOF is the annual reward and incentive programme which awards surgeries achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. Data that we looked at showed that reviews for NHS health checks for the year 2013/2014 were in the middle range for the local CCG, although there had been an improvement from the previous year. The practice manager told us that the demographics of the practice meant that patients were continually moving and many patients could be difficult to reach for annual checks or recalls. A dedicated clinic was in place as a method of reviewing patients.

Patients on repeat prescriptions were invited for reviews to assess their progress and ensure that their medicines remained relevant to their health need.

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 practice had an ante natal clinic held by a midwife once a week and this allowed for joint working and improved communication between staff at the practice and the midwife.

Babies and children were given same day appointments when they were ill and babies were invited for a six week check with the GP as part of the healthy child programme. This check was coordinated with the mother's six week post natal check. The practice also had a weekly childhood immunisations clinic undertaken by the practice nurse.

The practice had a number of health visitors allocated to them due to the geographical area covered by the practice and the corporate case loads of health visitors. Patients were given a central contact number for the health visitors should they need to contact them direct.

The practice was located in central Leicester and near universities as a result there were a large number of young patients registered at the practice. In an attempt to encourage and promote the health needs of young people, chlamydia screening kits were made available in the waiting area of reception and offered as part of the health check for new patients. All patients including young people completed an alcohol screening form as part of the registration process.

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

A late night surgery was available on a Monday evening and was aimed at working patients who could not always get to practice during the day.

NHS health checks were available to patients between 40 years and 74 years. These aimed to help reduce the incidence of stroke, diabetes heart and kidney disease.

There were posters displayed in reception inviting patients to join the practice participation group (PPG) which are a way in which patients and GP surgeries can work together to improve the quality of the service. Some of the members of the PPG were patients who had recently retired and were keen to improve the quality of the service.

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

All patients who had a learning disability were given an annual health check.

The practice was based in Leicester City centre which had local facilities for people who were homeless or an immigrant.

Patients aged 16 years to 35 years who arrived in the UK in the last five years were referred to the TB screening service. An interpreting service was available to patients whose first language was not English although this was not widely publicised in the practice and there were no information leaflets available in other languages.

Systems were in place to refer vulnerable patients to relevant agencies and healthcare professionals to ensure their health and wellbeing.

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 last appointment slot of the day was reserved for patients with urgent mental health needs. A 20 minute appointment was given to patients with mental health needs as they often required longer than the standard allocated time of 10 minutes.

A local mental health service called Improving Access to Physiological Therapies (IAPT) supported patients with mental health needs. The IAPT service had a clinic once a week at the practice to assess and review registered patients who were experiencing poor mental health. Patients with mental health needs were treated according to NICE (The National Institute for Health and Care Excellence) guidelines to ensure best practice was followed.

We saw that information displayed in the practice waiting area promoted a range of support groups such as Open Mind, First Step, and Domestic Abuse Disclosure Scheme. Emotional support was available for patients and carers and they were also signposted to other support networks.