Earls Court Medical Centre

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.

Summary of findings

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Summary of findings

Overall summary

Earls Court Medical Centre provides primary medical services through a General Medical Services (GMS) contract to people in the local community.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

During our inspection we spoke with eight staff and five patients. We also received feedback through the CQC comment cards.

We found that the service had some systems in place to manage patients' safety. Staff received appropriate training and professional development to deliver safe and effective care. The service was responsive to patients' needs and used feedback and complaints to improve. However, there were some areas where improvements needed to be made. We found that opportunities existed to improve outcomes for patients based on the practices' Quality Outcomes and Framework (QOF) performance. The service could not provide evidence of completed audit cycles and therefore it was not clear how patient care had improved as a result. We found that learning from serious incidents had taken place but there was no evidence that learning had been shared with all staff and there were no contingency plans in place to ensure continuity of care for patients in the event of a major disruption to the service.

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 provided was safe however areas for improvement were identified. There were policies and procedures for staff to follow to recognise and act upon any serious events, incidents or accidents. Staff were aware of the these. Significant events had been analysed by individual GPs and learning points recorded. However, there was no evidence that learning was shared with all staff.

The provider had systems in place to safeguard patients at risk of harm and protect patients from the risks associated with the management of medicines and infection control. Arrangements were in place to deal with medical emergencies and plans in place to deal with staff shortages.

Patients we spoke to said they felt safe.

Are services effective?

The service provided was not effective. There was no evidence of completed audit cycles to evaluate and improve patient care and the provider had not identified opportunities to improve outcomes for patients based on the practices' Quality Outcomes and Framework (QOF) performance.

We found that patients needs were met by suitably qualified and experienced staff working to recognised best practice standards and guidelines. Staff had received adequate training and development to deliver effective care to patients.

The provider proactively engaged with other organisations and professionals to coordinate care and meet patients needs.

Are services caring?

The service provided was caring. Patients were positive about their experience of the service. Staff were polite and caring and responded to patients' needs. Procedures were in place to protect patients' privacy, and to keep information about them and their medical records confidential and secure. Patients said the GPs involved them in decisions about their care and treatment and consent was always sought.

Are services responsive to people's needs?

The service provided was responsive to people's needs. The provider was responsive to patients' feedback and complaints. Results of surveys had been analysed and improvements made to the service as a consequence. Complaints had been investigated and satisfactorily resolved where possible.

Summary of findings

Are services well-led?

There was a clear management structure with individual staff members having specific roles and responsibilities. Staff that we spoke with were clear about who they could approach with any concerns they might have.

Staff said they were supported and valued to carry out their job roles but we found that learning from incidents was not shared with staff, no evidence of staff meetings and no evidence of completed audit cycles to improve outcomes for patients.

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 provider had arrangements in place to meet the needs of older people including working with other healthcare professionals to improve the quality of care and procedures to protect vulnerable older people from harm.

People with long-term conditions
The provider had arrangements in place to manage patients with long term conditions including designated roles for staff to take responsibility for specific disease areas. GPs followed the appropriate guidance for the management of long term conditions. However, we found that opportunities existed to improve outcomes for patients.

Mothers, babies, children and young people
The provider had arrangements in place to meet the needs of mothers, babies, children and young people. This included clinics, immunisation programmes and counselling services. Procedures were in place to ensure children and young people received appropriate care and were protected from harm.

The working-age population and those recently retired
The provider had arrangements in place to meet the needs of working age people including extended surgery hours, a health check service and advice on healthy living tailored to this age group.

People in vulnerable circumstances who may have poor access to primary care
There was some evidence that the provider had met the needs of people in vulnerable circumstances who may have poor access to primary care. This included working on a project to improve the health of a local population of drug users and a service to meet the health needs of patients with learning disabilities.

People experiencing poor mental health
Procedures were in place to meet the health needs of people experiencing poor mental health.

Summary of findings

What people who use the service say

Patients who attended the medical centre were satisfied with the service. They told us the reception team had improved and they could get an appointment when they needed one. They also said the waiting time for reception staff to answer the telephone had improved. Patients said the doctors were caring and the staff and management were always very helpful.

The comment cards we received from patients were also positive. Patients commented that the service remained good and consistent although there had been a lot of changes in staff. They said it was overall a good service, friendly and polite staff and clean inside.

Areas for improvement

Action the service MUST take to improve

No evidence that learning from incidents, accidents and significant events was shared with all staff.

No evidence of completed audit cycles to evaluate and improve patient care.

Analysis of quality and Outcomes Framework (QOF) performance to target patients needs.

No schedule to formally meet with staff and no evidence of meetings minuted with actions.

No arrangements to ensure continuity of care for patients in the event of a major disruption to the service.

Good practice

Our inspection team highlighted the following areas of good practice:

Proactively established relations with a minority ethnic community to encourage them to access the practices' healthcare services.

Involvement in projects to improve the health of vulnerable people who had poor access to primary care services including a project to improve the health of a local population of drug users and a service to meet the health needs of patients with learning disabilities.

Earls Court Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. It included a GP and a GP Practice Manager. They were all granted the same authority to enter Earls Court Medical Centre as the CQC inspectors.

Background to Earls Court Medical Centre

Earls Court Medical Centre is located in Earls Court Road in London and was originally known as the Om Sai Medical Centre. The premises were purpose built to deliver primary medical services through a General Medical Service (GMS) contract. The medical centre is set out over three floors with suitable access for patients with mobility needs. The staff comprise of five GPs, a nurse, a healthcare assistant, a practice manager and a small team of reception staff. The medical centre is situated in the London borough of Kensington and Chelsea serves an ethnically diverse and transient population of approximately 5700 people with a high proportion of 20-39 year olds. The medical centre is part of NHS West London Clinical Commissioning Group (CCG).

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 a mental health problem.

Before our visit, we reviewed a range of information we hold about the service and asked other organisations such as HealthWatch, NHS England and the CCG to share what they knew about the service. We carried out an announced visit on 21 May 2014. During our visit we spoke with a range of staff including three GPs, two non-clinical staff, the practice nurse, a healthcare assistant and the practice manager. We spoke with five patients to obtain feedback about the service and looked at three completed comment cards. We also reviewed complaints records, staff files, training records and other appropriate documentation.

Are services safe?

Summary of findings

The service provided was safe however areas for improvement were identified. There were policies and procedures for staff to follow to recognise and act upon any serious events, incidents or accidents. Staff were aware of the these. Significant events had been analysed by individual GPs and learning points recorded. However, there was no evidence that learning was discussed and shared with all staff.

The provider had systems in place to safeguard patients at risk of harm and protect patients from the risks associated with the management of medicines and infection control.

Arrangements were in place to deal with medical emergencies and there were plans in place to manage staff shortages.

Patients we spoke to said they felt safe.

Our findings

Safe patient care

Procedures were in place for staff to follow in the event of an incident, accident or significant event. Staff had access to the providers' online incident reporting form and an accident book was kept at reception to document any accidents as they occurred. Staff were able to describe the procedure for reporting incidents, accidents and significant events.

Learning from incidents

We saw examples of where individual GPs had analysed significant events and learning points recorded. However, there was no evidence that learning was discussed and shared with all staff to reduce the likelihood of reoccurrence. Procedures were in place to respond to safety alerts, any safety alerts received were distributed to individual clinicians and acted on.

Safeguarding

The provider had policies and procedures for staff to follow in relation to safeguarding vulnerable adults and children including the procedure for referring any concerns to the local safeguarding authority. Staff understood the different types of abuse of adults and children and were able to describe the steps to take if they had any suspicions of abuse happening. GPs had completed training in safeguarding adults and children and the training was refreshed on an annual basis to ensure knowledge was up to date and relevant.

The designated GP for safeguarding was involved in regular case reviews with the health visitor to discuss 'at risk' children. The nursing director reviewed cases involving older at risk patients. Where any issues were identified action plans had been put in place. Systems were in place for receiving safeguarding information from external organisations and this was recorded securely on the practice computer system. All staff were aware of how to raise whistleblowing concerns both within the service and with external organisations to ensure patients were protected from risks associated with poor practice.

Medicines management

We found that appropriate arrangements were in place for the storage of medicines. Medicines were stored in a locked cabinet in a designated room. Access to the room was strictly controlled to prevent unauthorised entry. The

Are services safe?

practice nurse was responsible for ensuring medicines were in stock and within their expiry dates. We saw evidence that the expiry dates of medicines including controlled drugs were monitored on a regular basis. Vaccines were stored within the correct temperature range and daily temperatures checks were carried out and recorded. Prescription pads were kept securely. Systems were in place to ensure patients received their repeat prescriptions in a timely manner and their medicines reviewed appropriately.

Cleanliness and infection control

The provider had policies and procedures in place to minimise the risk of cross infection and these were followed by staff. All clinical staff had completed training in infection control and were aware of their responsibilities. We observed that all areas of the service were visibly clean and well kept. Consultation rooms were well equipped with hand washing facilities including hand sanitising liquids and paper towels. Hand wash posters were displayed setting out the correct hand washing techniques as a quick reference and reminder for staff. A plentiful supply of personal protective equipment was available including gloves and disposable aprons. Sharps waste and clinical waste were segregated and stored safely and the provider had a contract with a professional waste company to ensure its safe disposal. Cleaning schedules were in place and a professional cleaning company cleaned the practice on a daily basis to ensure cross infection risks were minimised. Audits had been carried out to monitor infection control standards.

Staffing and recruitment

Appropriate pre-employment checks had been completed for staff to ensure they were of suitable character to work for the service. We saw evidence that references had been successfully taken up for all staff pre-employment. Disclosure and Barring Service (DBS) checks had been completed for some staff. However, we found that DBS checks had not been completed for all reception staff recently employed by the provider. The practice manager informed us that DBS checks had been sought retrospectively as there had been an urgent requirement for new reception staff. We saw evidence that the DBS checks had been requested and the practice manager assured us that the new reception staff were under the supervision of the reception manager to ensure they were suitable for the job role.

Dealing with Emergencies

The provider had policies and procedures in place to deal with foreseeable emergencies. Staff had completed training in basic life support and anaphylaxis (acute allergic reaction) management and refresher training was carried out annually to update knowledge. An emergency anaphylaxis kit was stored in each consultation room and an oxygen cylinder was available for immediate use. Staff were able to describe the procedure to follow in the event of an emergency which meant they could respond promptly and effectively if the need arose. Staff had been trained in fire safety and fire drills had been rehearsed to ensure patients and staff could be evacuated safely in the event of a fire.

Monitoring safety and responding to risk

There were plans in place to respond to staff shortages. The provider had access to agency staff to cover non-clinical staff members and the GPs covered each other during periods of annual leave. The provider also had access to locums through a locum agency if GPs were absent for longer periods. The provider had carried out a health and safety risk assessment to ensure the environment was safe for patients and staff. We found that where risks had been identified control measures were in place to mitigate them.

Equipment

We found that the service was spacious and well maintained. All the consultation rooms had appropriate clinical equipment and calibration checks had been completed. Patients with restricted mobility could access the service and toilet facilities had been modified to accommodate them. Lifts were also available to transport patients with mobility needs between floors so they had access to all areas of the service.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service provided was not effective.

There was no evidence of completed audit cycles to evaluate and improve patient care, the provider had not identified opportunities to improve outcomes for patients based on the practices' Quality Outcomes and Framework (QOF) performance.

We found that patients needs were met by suitably qualified and experienced staff working to recognised best practice standards and guidelines. Staff had received adequate training and development to deliver effective care to patients.

The provider proactively engaged with other organisations and professionals to coordinate care and meet patients needs.

Our findings

Promoting best practice

The GPs and nurse provided evidence based care and treatment in accordance with recognised guidance. For example GPs worked to the quality standards set by the National Institute for Health and Care Excellence (NICE) and the British Medical Association (BMA). GPs had designated roles in the management of specific disease areas and used appropriate guidance to keep their clinical knowledge up to date.

Management, monitoring and improving outcomes for people

GPs were able to describe some audits they had completed. These included audits of prescribing and accident and emergency attendances. However, during our inspection the provider was unable to show us evidence of these audits and therefore it was not clear what improvements had been made to patient outcomes as a result.

The provider had not used their Quality and Outcomes Framework (QOF) performance to identify and improve outcomes for patients. The QOF is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. We found that there was no analysis of recent QOF performance and opportunities to improve outcomes for patients had not been identified and followed through. For example there were opportunities to improve outcomes for patients with long term conditions such as cardiovascular disease and diabetes and services such as cervical screening and contraceptive services.

Staffing

We reviewed the training records for staff and found that training was relevant and up to date and staff were supported to gain the right skills and knowledge to deliver effective care to patients. Training included health and safety, information governance, infection control and safeguarding children and adults. The practice manager completed annual appraisals with non-clinical staff and the doctors completed them with clinical staff. The purpose of the appraisals was to assess staff performance and identify any development needs with an overall aim of providing effective care to patients. However, we found that newly appointed reception staff had not received induction training when they started working for the provider to

Are services effective?

(for example, treatment is effective)

ensure they were competent to perform their duties and meet patients' needs. The practice manager assured us that the new reception staff were being mentored by the head receptionist until they were competent at their job role and had completed mandatory training.

Working with other services

The provider fostered a close working relationship with other health and social care professionals and organisations. These included the community mental health team, the district nurses, the palliative care nurse and the community psychiatric nurse. GPs worked with a primary care navigator to improve care for patients in a local nursing home. The GPs also worked in collaboration with other practices to offer a weekend walk-in service which was open to all patients from local practices. The provider was part of a peer review group of practices with a view to share best practice and improve patient care.

Regular case management meetings were held involving the GPs, the district nurse and the primary care navigator with an aim of improving the quality of care for patients managing complex and long term conditions.

Health, promotion and prevention

The service provided a variety of clinics with an aim of promoting good health. These included a smoking cessation clinic, pre-pregnancy counselling and a health check clinic for 40–74 year olds. The designated GP for immunisations and the practice nurse worked as a team to ensure children requiring immunisations were protected against disease. The practice had information leaflets available on a range of health conditions and healthy living advice. The providers website also contained information to promote a healthy lifestyle including exercise and sexual health advice.

Are services caring?

Summary of findings

The service provided was caring. Patients were positive about their experience of the medical centre. They said staff were polite, caring and responded to their needs. Procedures were in place to protect patients' privacy, and to keep information about them including their medical records confidential and secure. Patients said the GPs involved them in decisions about their care and treatment and their consent was always sought.

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed that staff were friendly, polite, empathetic towards patients and strived to meet their needs. We noted that there was a separate room adjacent to the reception area where conversations could be held with patients in private and consultations were carried out with the door closed to ensure conversations could not be overheard. All staff had received training in data protection and patients medical records were stored confidentially. Practice information leaflets were available at reception containing information on confidentiality and how patients could access their records. This meant that patients could be assured that their personal and sensitive information was held confidentially at all times. We spoke with five patients who were in the waiting area and viewed three comment cards. Patients were positive about the service. They said the service was professional and the staff and management always very helpful. Patients said the GPs were caring and they were happy with the service provided.

Posters were displayed informing patients that a chaperone was available to accompany them during a medical examination if they so wished and an interpreter service was available for patients whose first language was not English to help them with their communication needs.

Involvement in decisions and consent

We saw that the patient waiting areas were spacious with adequate seating. Health promotion and information about the service were available in the waiting areas. Patients informed us that the GPs involved them in decisions relating to their care. Patients said that the GPs took time to explain their health conditions and the advantages and disadvantages of different treatment options. Procedures were in place for gaining informed consent from patients before conducting examinations and written consent was sought for minor surgery. Patients were offered a choice of a male or female GP at the time they booked their appointment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service provided was responsive to people's needs. The provider was responsive to patients feedback and complaints. Results of surveys had been analysed and improvements made to the service where necessary. Complaints had been investigated and satisfactorily resolved where possible.

Our findings

Responding to and meeting people's needs

The provider used data from surveys and attended regular local network meetings with other practices to plan their services to meet the needs of the local population. Services offered by the practice included a counselling service, an antenatal clinic, immunisation clinic and a baby check clinic. The needs of patients in vulnerable circumstances were also considered. For example the provider had worked on a project in collaboration with Public Health England to improve the health of a local population of drug users. The provider had also addressed barriers to care with different population groups. For example relations with a hard to reach group of patients had been successfully established. This involved a GP introducing themselves to the 'chief' of one particular ethnic group to build trust and awareness of local healthcare services and increase registration rates among this group of people with the practice.

Access to the service

Patients informed us that they could usually book an appointment when they needed one. At the time of our inspection the provider was in the process of making improvements to the appointment system in response to patient feedback and an increasing demand for appointments. This included the introduction of an online booking system and improvements to the telephone queue system. Other measures to improve access included a nurse triage system, a duty doctor, walk-in slots and daily telephone consultations. Home visits were also available for patients who were housebound. Translation services were available for patients whose first language was not English to help them with their communication needs and the appointment check-in system was accessible in languages appropriate to patients using the service.

Concerns and complaints

The provider had a complaints procedure in place and it was available at reception. The procedure was detailed and included information about external organisations patients could contact if their complaint was not resolved satisfactorily by the practice. We viewed the complaints log for the previous year. The provider had received 10

Are services responsive to people's needs?

(for example, to feedback?)

complaints over the 12 month period, eight had been resolved satisfactorily and two were on-going. Where complaints were on-going people were kept informed of the progress of the investigation.

The practice had completed a patient survey in the previous year, the results had been analysed and shortfalls identified. In collaboration with the Patient Participation Group (PPG) the practice had produced an action plan with timescales for implementation. We saw evidence that the practice was in the process of implementing the changes required to make improvements to the quality of care provided. For example the implementation of online services for appointment booking and prescription ordering and offering telephone consultations to improve patient waiting times.

Are services well-led?

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

Summary of findings

There was a clear management structure with individual staff members having specific roles and responsibilities. Staff that we spoke with were clear about who they could approach with any concerns they might have.

Staff said they were supported and valued to carry out their job roles but we found that learning from incidents was not shared with all staff, no evidence of regular staff meetings and no evidence of completed audit cycles to improve outcomes for patients.

Our findings

Leadership and culture

At the time of our inspection the practice was going through a period of changes to the staff team. The provider was in the process of recruiting a full time practice manager and in the meantime an interim practice manager was in post. A new reception team had also been recruited with all reception staff in post for 12 weeks or less. Staff members informed us that the culture of the service was one of mutual support and collaborative team work. The vision and strategy for the service was in the process of being developed.

Governance arrangements

Individual staff members had clearly defined roles and responsibilities covering specific areas of the service provision. This included designated roles for safeguarding children, infection control, health and safety, management of medicines, and the management of long term health conditions. Staff were aware of their responsibilities and who they would report to if they had any issues or concerns. Decisions relating to the running of the practice were always agreed between the practice manager and the practice partners before any changes were implemented.

Systems to monitor and improve quality and improvement

The practice had some systems in place to monitor its performance to improve the quality of care provided. For example surveys had been carried out and patient feedback acted on. However, during our inspection there was no evidence of any completed audits and therefore no evidence of improvements in patient care made as a consequence of such audits.

Patient experience and involvement

The practice had an active Patient Participation Group (PPG) in order to engage further with patients, gain valuable feedback about the services the practice provided, and to identify where improvements could be made. The PPG was a virtual PPG made up of 12 patients who were willing to be contacted by email. The provider recognised that the PPG was small and was actively working towards increasing the number of members by encouraging patients to join. The PPG had an active role in decisions relating to the running of the practice and was an important voice for patients concerns.

Are services well-led?

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

Staff engagement and involvement

Staff informed us that they felt involved in the service and worked as a team to deliver a quality service. They said that regular meetings took place in the past for both clinical and non-clinical staff to discuss any concerns or issues they might have. However, staff said that in recent times no meetings had been held. The practice manager confirmed that there was no schedule in place to formally meet with staff and no formal meetings had been held. The practice manager acknowledged these shortfalls and agreed that meetings and communication with staff were an area for improvement.

Learning and improvement

Incident reporting systems were in place, however, they were not sufficiently robust to ensure that learning was systematically shared across the organisation. For example significant events were recorded and investigated by individual GPs and kept on their computer system. However, there was no evidence that learning was discussed and shared with all staff to reduce the likelihood of similar incidents happening in the future.

Identification and management of risk

There was no evidence that the provider was taking a proactive approach to anticipating potential major disruptions to the service which could impact continuity of patient care. There were no contingency plans in place to identify and mitigate any foreseeable risks. The practice manager acknowledged that this was a shortfall in their system and was an area for improvement.

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.

Summary of findings

The provider had arrangements in place to meet the needs of older people including working with other healthcare professionals to improve the quality of care and procedures to protect vulnerable older people from harm.

Our findings

The provider had systems in place to meet the needs of older people. For example the practice provided a service for a large care home. The GPs liaised with other health care professionals to improve care for elderly residents living at the home.

GPs were trained to recognise signs of abuse in vulnerable older people and procedures were in place to report any concerns to the local safeguarding team to protect them from harm.

Procedures were in place to review older patients who were at risk of repeated acute hospital admission for those with complex health needs. Reviews were carried out by the GPs and the nurse director and action plans were formulated for patients assessed to be high risk to ensure the likelihood of hospital admission was reduced.

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).

Summary of findings

The provider had systems in place to manage patients with long term conditions including designated roles for GPs to manage specific disease areas. GPs followed the appropriate guidance for the management of long term conditions. However, opportunities existed to improve outcomes for patients in specific disease areas.

Our findings

GPs had designated roles in the management of patients with long term conditions and were following recognised guidance. The provider ran long term condition clinics to meet patients' needs. These included asthma and diabetes clinics. However, we found that opportunities existed to improve outcomes for patients with long term conditions but these had not been identified. The practice had not analysed their QOF data which highlighted a number of disease areas where improvements to patient outcomes could be made. These included asthma, diabetes and cardiovascular disease. The provider was not being proactive in reviewing patients managing these long term conditions.

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.

Summary of findings

The provider had arrangements in place to meet the needs of mothers, babies, children and young people. These included various clinics, immunisation programmes and counselling services. Procedures were in place to ensure children and young people received appropriate care and were protected from harm.

Our findings

The provider offered a range of services for mothers, babies, children and young people. These included pre-pregnancy counselling, antenatal and baby check clinics. There was a designated GP for child immunisations who liaised with the practice nurse to ensure children were targeted for immunisations. GPs attended child protection case reviews with the healthcare visitor on a regular basis where issues relating to 'at risk' children were addressed to protect them from harm. All staff had received training in safeguarding children and young people and were aware of the steps to take if they had any concerns. Procedures were in place to assess children's ability to give consent and recognised guidance such as the Children Act was followed to ensure children received appropriate care.

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.

Summary of findings

The provider had arrangements in place to meet the needs of working age people including extended surgery hours, a health check service and advice on healthy living tailored to this age group.

Our findings

Arrangements were in place to meet the needs of working age people. For example the provider had introduced extended surgery opening hours in the evenings on weekdays so patients who could not attend an appointment during the day because of work commitments could see a GP or nurse in the evening.

A health check service was available for patients aged between 40 and 74 years to assess their health with an aim to prevent disease. The checks included lifestyle, smoking cessation and alcohol awareness advice.

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).

Summary of findings

There was evidence that the provider had met the needs of some people in vulnerable circumstances who may have poor access to primary care. This included working on a project to improve the health of a local population of drug users and a service to meet the health needs of patients with learning disabilities.

Our findings

We found that the provider had some experience of providing care to people in vulnerable circumstances. For example the practice had worked on a project in collaboration with Public Health England to improve the health of a local population of drug users. The provider also offered a Local Enhanced Service (LES) to target the needs of patients with learning disabilities. Patients had been identified and care plans put in place.

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.

Summary of findings

Procedures were in place to meet the health needs of people experiencing poor mental health.

Our findings

GPs worked with the mental health team to help assess patients' mental capacity if appropriate. There were processes to refer patients to specialist health services. This involved the input of the community psychiatric nurse who liaised with a mental health social worker to ensure the patient was seen and appropriate care was arranged.

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because learning from serious incidents had not been shared with all staff, contingency plans were not in place to manage risks to patients in the event of a major disruption to the service and there was no evidence of clinical audits to evaluate and improve outcomes for patients. Regulation 10 (1) (a) (b).