North Laine 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

North Laine Medical Centre is located in the centre of Brighton and provides primary care medical services to approximately 3980 patients in the locality. The practice has three general practitioners (GPs), all of whom form the partnership management team as the registered provider of services at the practice. The services are within the Brighton and Hove Clinical Commissioning Group (CCG). We spoke with 9 patients during our inspection and they were all very complimentary about the services they received from the practice. We also received many positive comments from patients who had completed CQC comment cards prior to our inspection. They all expressed a high level of satisfaction with the practice and staff. We also spoke with the patient participation group (PPG) representatives, who emphasised the support, engagement and effective working relationship the group had with the practice management team. We also saw the results of a recent patient survey that showed patients were consistently pleased with the service they received.

We spoke with the whole clinical team, the three GPs, the practice nurse and all the staff on duty who were not nurses or GPs. They told us that the management were open and approachable and that there was good team working amongst all the staff at the practice.

We had some concerns about the lack of a comprehensive whistleblowing policy and the lack of a policy for safeguarding vulnerable adults and the fact that the practice did not undertake formal supervisions that were documented.

Overall, we found that the practice was well-led and provided caring, effective, and responsive services to a wide range of patient groups, including those of working age and recently retired, mothers with babies and younger children, older people, patients with long-term conditions and complex needs, people in vulnerable circumstances and those people experiencing poor mental health. However, we considered that the concerns we had regarding the whistleblowing and safeguarding vulnerable adults policies had an impact across all or most patient groups and as such these areas required improvement.

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. However, we had concerns about the lack of a safeguarding policy for vulnerable adults. We were also concerned that the whistleblowing police was not comprehensive. The practice had policies for maintaining patient confidentiality and infection control amongst others. Care and treatment was provided in a clean and safe environment.

Are services effective?
Patients experienced an effective service. There were measures in place to monitor the delivery of treatment, clinical audits, reviews and multidisciplinary working were used to improve outcomes for patients.

Are services caring?
Patients experienced a caring service. The comments we received were all positive. The practice's March 2014 patient survey showed that a majority of patients were extremely likely or very likely to recommend the practice to family and friends.

Are services responsive to people's needs?
The practice was responsive to patients' needs. Patents were given the opportunity to make suggestions to improve the practice through the active patient participation group which the practice set up to channel those suggestions to the management team. In addition patients can raise issues with the practice through the practice website. We saw evidence that changes had taken place as a consequence of patient feedback.

Are services well-led?
The practice was well-led. The management team developed an open and democratic culture where all staff were able to freely raise issues and concerns. This open culture was felt to instrumental in promoting shared learning between colleagues.

Summary of findings

The six population groups and what we found

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

Older people

We had some concerns about the safety of services provided at the practice for patients with long-term conditions.

We had some concerns that there was not a safeguarding policy to support vulnerable adults/older people.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also present a risk to patients.

We found that the practice had a good recruitment policy and appropriate professional/safety checks had been carried out when staff were recruited. For example we saw that the practice took up the references provided.

The practice offered annual flu vaccinations routinely to older people to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered to older people for example all patients over seventy-five had a named GP and a care plan. The practice was responsive in meeting the needs of older people and in recognising future demands in service provision for this age group. The practice was well-led in relation to allocating a named lead GP to each patient in this population group and channelling its resources and efforts to the particular demographics of patients who are registered with them.

People with long-term conditions

We had some concerns about the safety of services provided at the practice for patients with long-term conditions.

We had some concerns that there was not a safeguarding policy to support adults with long-term conditions.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also present a risk to patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

The practice offered annual flu vaccinations routinely to people with long-term conditions to help protect them against the virus.

We found the practice to be caring in the support it offered to patients with long-term conditions and that the care provided was

satisfactory, treatment pathways were monitored and kept under review. The practice was responsive in prioritising urgent care that people required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Mothers, babies, children and young people

We had some concerns about the safety of services provided at the practice for mothers, babies, children and young people.

The practice had a safeguarding policy that reflected the arrangements for protecting children from the risks of abuse. They also had a safeguarding lead This meant that staff were able to recognise or have awareness of the risks of abuse for vulnerable children.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

The practice offered annual flu vaccinations routinely to mothers to help protect them against the virus.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for babies, children and young patients.

We found that the practice was responsive to patients who know that they are pregnant by asking them to make an appointment to see their GP.

The working-age population and those recently retired

We had some concerns about the safety of services provided at the practice for working age patients.

The practice had a safeguarding policy that reflected the arrangements for protecting children from the risks of abuse. But they did not have a policy for vulnerable adults.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

The practice offered annual flu vaccinations routinely to patients at risk to help protect them against the virus.

Summary of findings

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for working age patients.

We found the practice to be caring in the support it offered to working age and recently retired patients, and were responsive in reviewing opening hours.

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

We had some concerns about the safety of services provided at the practice for people in vulnerable circumstances who may have poor access to primary care.

We had some concerns that there was not a safeguarding policy to support vulnerable adults.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

The practice offered annual flu vaccinations routinely to people who may be vulnerable and at greater risk, to help protect them against the virus.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for patients in vulnerable circumstances who may have poor access to primary care.

We found that the practice was caring about vulnerable patients, in particular, the premises were accessible and suitable for patients with reduced mobility. There was effective support from the practice for vulnerable people in the community and the practice was responsive in providing care and treatment at patients' homes who found it difficult to attend the practice.

People experiencing poor mental health

We had some concerns about the safety of services provided at the practice for people experiencing poor mental health.

We had some concerns that there was not a safeguarding policy to support vulnerable adults.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

Summary of findings

The practice offered annual flu vaccinations routinely to people who may be vulnerable and at greater risk, to help protect them against the virus.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for patients in vulnerable circumstances who may have poor access to primary care.

We found the practice had a caring approach to patients who may be experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments, and were responsive in referring patients to specialist service providers for ongoing support. Management provided a satisfactory approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

Summary of findings

What people who use the service say

Prior to the inspection we left CQC comment cards for patients, family or friends or their supporters to voluntarily complete. We received many positive comments from the patients who had completed the comment cards. We also spoke with representatives of the patient participation group (PPG), who emphasised the support and the effective working relationship they had with the practice and the management team.

Areas for improvement

Action the service COULD take to improve

The practice should have a safeguarding adults policy in place for staff to refer to.

The practice should have a comprehensive whistleblowing policy that details the action(s) to take, and contains the full contact details of other bodies that staff can contact if they have concerns.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was innovative in its methods of engaging with their patients. In addition to the usual methods it used their website and text messaging.

North Laine Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP providing clinical lead and the team included a CQC inspector and two specialists: Specialist in Practice Management and an Expert by Experience in primary medical care.

Background to North Laine Medical Centre

The practice is located in the heart of the North Laine in the Brighton City Centre. It is a three GP partnership. The practice is regulated to provide Diagnostic and Screening Procedures, Treatment for Disease, Disorder and Injury, Maternity and Midwifery. They provide those NHS services for approximately 3980 patients in the locality. Their patients come from wide ethnic, cultural and social backgrounds

Health care clinics are offered at the practice, led by a practice nurse. There are a range of patient population groups that use the practice, comprising mostly patients of working age, older people, recently retired people, and mothers with babies, children and young people.

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.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations such as the local clinical commissioning group and Healthwatch to share what they knew about the service. We carried out an announced visit on 27 May 2014. During our visit we spoke with a range of staff. Our GP clinical lead and inspector spoke with all the clinical staff (three GPs and the practice nurse). The practice manager specialist and lead inspector spoke with the practice manager. The lead inspector also spoke with all the administrative staff on duty. The lead inspector and inspector spoke with representatives of the patient participation group. In addition our expert by experience spoke with nine patients who attended the practice on the day of the inspection. We reviewed CQC comment cards that we had provided prior to the inspection, where patients and members of the public shared their views and experiences of using the practice with us. We also observed how patients were supported by reception staff in the waiting area before they were seen by members of the clinical team. We used those methods to gather information from people who use services and staff.

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:

Detailed findings

- 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.

Are services safe?

Summary of findings

Overall the service was safe. However, we had concerns about the lack of a safeguarding policy for vulnerable adults. We were also concerned that the whistleblowing police was not comprehensive. The practice had policies for maintaining patient confidentiality and infection control amongst others. Care and treatment was provided in a clean and safe environment.

Our findings

Safe patient care

The practice had an infection control lead (ICL). We saw a recent infection control audit that was completed by the infection control lead (ICL). It was comprehensive and based on National Institute for Health and Clinical Excellence (NICE) clinical guidelines to ensure quality. The audits included actions to be taken. We saw evidence that actions had been taken in response to the audit, for example, a damaged chair had been recovered. However, there was no evidence of any action plans having been draw-up or follow-ups scheduled to ensure the actions had been completed. We discussed our findings with the practice manager who agreed that there was no formal basis to ensure that the actions proposed by the audits were reviewed and completed and that the relevant staff were made aware of the outcomes. The audits were reviewed at the following annual audit to check that improvements had been made as a result of the changes or actions taken.

Learning from incidents

Staff told us that the provider held monthly meetings which included discussions about safety incidents, concerns or near misses. We saw notes of the meeting dated 22 May 2014. The notes showed that all staff and clinicians were present. The notes included four items described as significant events. We saw evidence that the incidents had been reviewed and action and learning was shared with all staff. For example a GP discovered that a referral letter had not been sent as required. A policy was introduced that ensured GPs confirmed that referral letters had been sent.

Safeguarding

The practice manager stated that all staff had received safeguarding training: level 1 for non-clinical staff; level 2 for the nurse and level 3 for the GPs. The staff training matrix we saw showed staff had received safeguarding training. In addition all staff we spoke with confirmed that they had received safeguarding training. Most staff said that they were confident that if they raised any safeguarding concerns they would be dealt with appropriately by senior colleagues. We saw that the practice had a safeguarding policy for safeguarding children and young people which included information on the types of abuse and indicators of potential abuse to be aware of. In addition there was

guidance on action to be taken when raising a safeguarding concern. The guidance also stated the name of the safeguarding lead at the practice. We saw that there were safeguarding notices on display around the practice which gave action points and contact details of external agencies that may need to be contacted to enable staff to respond to safeguarding concerns quickly. However, the provider did not have a safeguarding policy for vulnerable adults. The practice manager acknowledged this as an oversight. We saw evidence that staff had discussed, at their monthly staff meeting, their concerns about the financial abuse of a vulnerable patient. Some action was taken to support the patient but there was no evidence that a formal safeguarding process had been followed.

The practice had a chaperone policy setting out the arrangements for those patients who wished to have a member of staff present during clinical examinations or treatment. Only staff who had been trained could chaperone.

Monitoring safety and responding to risk

We saw that external safety alerts were received by fax or email. They were distributed in hard copy or emailed to all staff. Staff told us that they were required to sign to confirm that they had received and read the alert.

The practice had a process to ensure that there were sufficient staff to match appointments which included provision for additional clinical support following bank holidays and weekends.

The practice held weekly clinical meetings that were minuted. At these meetings staff discussed specific topics which included concerns about safety and risks

Medicines management

We saw that the practice had a process to check the expiry dates of the medicines they use. We also saw that a log was kept to record the daily temperatures of the refrigerator used to store medicines. We noted that all the drugs stored in the refrigerator were in date. The practice manager explained that they had a cold chain process in place and if the refrigerator failed they had an agreement with a neighbouring pharmacy to temporarily store the refrigerated drugs.

Cleanliness and infection control

On the day of our inspection all the clinical area and public areas for example the lobby, hall way and reception were clean and tidy. A member from the patient participation group we spoke with told us that the practice was always clean and tidy and staff always wash their hands. Sanitising hand gel was available for patients and visitors. We saw cleaning schedules for cleaning the premises which showed that the whole of the premises were cleaned on a daily basis. We were told that the practice used a colour coding system to identify which cleaning equipment should be used in designated areas. We noted that clinical waste was securely kept in tied coloured bags and stored under lock and key prior to collection by a regulated waste collector for safe disposal. The practice kept signed records of the bags collected. The chairs in the clinical rooms and waiting room were easy to clean chairs.

We saw that the practice had an infection control policy which included a range of procedure and protocols for staff to follow, for example, hand washing, handling specimens, clinical waste, needle stick injuries, and personal protective equipment.

The practice had established storage processes with good contamination protection for the safe handling and transporting of laboratory specimens. They were collected daily by courier. There were arrangements in place so that the practice could be assured as far as possible that the specimens would reach the laboratories safely and in a timely manner to the benefit of their patients in terms of diagnosis and treatment.

The practice staff records we were shown confirmed that all staff had been vaccinated against Hepatitis B. This meant that staff and patients were at a reduced risk of contracting and spreading Hepatitis B.

Staffing and recruitment

Staff told us that prior to appointing a new member of staff they always took up two references usually by telephone. Notes of the conversations were then retained in the individuals personal file. We saw that the notes were signed and dated by the practice manager. One member of staff told us that when she joined the practice she undertook a comprehensive induction programme which included guidance on keeping patient records confidential and health and safety protocols. Another member of staff described the practice's induction programme as useful.

Dealing with Emergencies

We saw from the training matrix that the majority of staff had received had received cardiopulmonary resuscitation (CPR) training, some of whom undertook their training in

Are services safe?

March 2014. The emergency equipment, oxygen, emergency drugs and defibrillator was located in the nurse's treatment room. We checked the emergency medicines and found them all to be within their use by dates. The service also had spillage kits available and personal protective equipment such as aprons, gloves and goggles for use when necessary. The practice nurse stated that she had trained staff on how to clean up spillages.

The practice had an emergency and business continuity/ recovery plan that included arrangements detailing how patients would continue to be supported during periods of unexpected and/or prolonged disruption to services. The practice had reciprocal arrangements with two other general practices nearby to provide support. The computer system they used allowed access to clinical records from these sites. Patients would be contacted and advised that they needed to attend these alternative locations to access the services they required.

Equipment

We saw records that demonstrated that equipment used at the practice was regularly maintained. For example blood pressure monitors were calibrated annually. In addition the portable electrical appliances were scheduled to be tested in December 2014.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients experienced an effective service. There were measures in place to monitor the delivery of treatment. Clinical audits, reviews and multidisciplinary working were used to improve outcomes for patients.

Our findings

Promoting best practice

We were told that the practice held monthly meetings for all staff. Staff told us that they have an opportunity to discuss issues at the meeting. We saw the minutes of the staff meeting dated 22 May 2014. The agenda items included the following: significant events, safeguarding and child protection, infection control update. The notes were succinct but detailed. We saw that information was openly shared with staff to promote best practice. For example, staff were reminded of process for collecting and secure storage of clinical waste. The practice also held quarterly meetings on a Wednesday for clinical staff. The practice manager told any staff that were unable to attend were given information about what was discussed at the meetings.

Records were kept of external safety alerts received by the service by fax or email. Staff told us that they were required to sign the alert to indicate that they have seen and read it. All GPs had access to the on-line NHS information services which enable them to receive and access up-to-date information. Clinical staff we spoke with demonstrated an awareness of the rights of patients who lacked capacity to make decisions and give consent and the application of the Mental Capacity Act 2005 applicable in general practice.

Management, monitoring and improving outcomes for people

Staff told us that they reviewed the Quality and Outcomes Framework (QOF) reports to improve the outcomes for their patients. QOF is part of the General Medical Services Contract, it is a voluntary incentive scheme for GP practices in the United Kingdom. The QOF gives an indication of the overall achievement of a practice through a points system. We saw records that showed that the practice had concentrated on mental health last year. The practice manager advised us that in addition to QOF the service focussed on the known demographics of their patient population to implement better targeted strategies to achieve good care, treatment and outcomes their particular patients. For example, they have focussed on HIV, substance abuse and mental health. The practice had a substance misuse lead who worked closely with a specialist nurse. They held substance misuse clinics on Wednesdays. We explained that our records indicated that

Are services effective?

(for example, treatment is effective)

the practice prescribed a high number of hypnotic medicines (hypnotics are sedatives reserved for short courses of treatment to alleviate acute conditions). The practice manager explained that they had records to show that they had recently reduced the hypnotics prescribing within the practice by twenty five per cent. The practice had made changes to their prescribing regime and they believed that this had benefited patients with specific conditions.

Staffing

Clinical staff told us that they attended external fora and events to ensure compliance with their continual professional development programme for example undertaking GP refresher courses at Sussex University.

Working with other services

We saw evidence that the practice enabled multi-disciplinary working with other care providers and partner agencies, to promote integrated and co-ordinated care pathways for patients. This included links with community nursing teams, for example, specialist mental health nurses who hold clinics at the practice and the palliative care team partnership. Multi-disciplinary meetings were held regularly and included clinicians from the practice, social services and community teams involved in patient care/treatments.

Health, promotion and prevention

The staff we spoke with told us that there were a range of services provided to promote health and well-being for patients, including routine health checks, follow-up checks for patients with long-term conditions, vaccinations and screening programmes. These were managed by a re-call system to help ensure patients received ongoing preventative care and support from the practice. Immunisation reminders were sent out by the nurse for travel vaccines. The Child Health Bureau advised which children needed to be called in for vaccination and the practice ran a vaccination programme to ensure they received their vaccinations. Children that failed to attend their vaccination appointments were followed up by the bureau in the first instance and then by the practice.

There were multiple information leaflets in the waiting room that offered information on health and well-being which included smoking cessation, alcohol awareness, drug abuse, vaccinations, lowering cholesterol, HIV, asthma and dementia. Information provided on the television screen included flu and travel vaccinations. One patient told us that at an annual review, staff had printed off on-line information for them to help them understand their long term condition. We also saw that the practice promoted health and well-being on its website.

Are services caring?

Summary of findings

Patients experienced a caring service. The comments we received were all positive. The practice's March 2014 patient survey showed that a majority of patients were extremely likely or very likely to recommend the practice to family and friends.

Our findings

Respect, dignity, compassion and empathy

The practice had a policy for protecting patient confidentiality and a copy was on display in the waiting room. The practice also displayed notices advising patients that chaperones were available. Staff told us that, in accordance with their policy, all patients who required intimate examinations were automatically offered a chaperone. This was confirmed when some of the patients we spoke with told us that they had been offered a chaperone. Clinical staff also told us that they always explain to patients that any procedure can be stopped at any time. Clear explanations were given for treatments, medicines and tests offered. They had also been given choices and options where available. We saw all the consulting rooms and the nurse's treatment room had privacy curtains. We saw from some of the comment cards that staff were very caring and patients were treated with dignity and respect.

The practice had modified a glass screen in the reception area by installing grills which helped maintain patient confidentiality when patients were speaking to staff at reception. In addition piped music was played in the waiting area that reduced the likelihood of conversations at the reception area being overheard. Staff told us that if patients preferred to speak to them in private they were offered a private room in which to have their conversations. A member of the patient participation group confirmed this when they told us that a separate room is available if you wish to speak to a receptionist in private. The staff we spoke with demonstrated how they considered patients' privacy and dignity during consultations and treatments, by ensuring that doors were closed and curtains were used in treatment areas to provide additional privacy.

We noted that the practice supported patients from different cultural backgrounds. For patients whose first language was not English, staff told us that that they frequently used a translation service and they did not use family members as interpreters.

Involvement in decisions and consent

We saw from the comment cards that patients felt involved in the decisions that were made about their care and treatment. We saw that the practice had a range of leaflets

Are services caring?

and sign-posting documents displayed for patient information, to help ensure patients were made aware of the options, services and other support available to them from within the practice and other health and social care providers. We spoke with staff who explained the discussions that took place with patients, to help ensure they had an understanding of their treatment options. One GP explained that for one dementia patient she wrote down everything following their appointments for the patient to consider in their own time. The GP also gave an example of a patient with learning difficulties who came in with their foster carer for an intimate examination. They went ahead with the procedure once they felt that the patient had understood what was going to happen and had obtained consent.

The practice had a patient participation group (PPG) who organised and co-ordinated regular meetings and patient surveys. We spoke with three representatives from the group who told us that they were supported and encouraged by the management to ensure patient views, comments and feedback were captured on a regular basis, to help inform some of the decisions made about how services were provided. They gave us the following examples of improvements to the practice that had occurred following meetings with the PPG: modifications to the glass screen in reception to enable discrete conversations to take place between patients and reception staff; patients could now book appointments up to one month in advance and telephones are answered more quickly than in the past.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. Patients were given the opportunity to make suggestions to improve the practice through the active patient participation group (PPG) which the practice set up to channel those suggestions to the management team. In addition patients could raise issues with the practice through the practice website. We saw evidence that changes had taken place as a consequence of patient feedback.

Our findings

Responding to and meeting people's needs

The practice was a patient centred practice. The practice manager explained that the practice focussed on the known demographics of their patient population in preference to the Quality and Outcomes Framework (QOF) scheme, despite this approach being financially detrimental to the practice. The practice nurse explained that they see the appointment list a few days before and can extend appointments for patients who may need extra time, for example patients with dementia or learning difficulties. Most of the patients we spoke with or commented on the comment cards we provided were very complimentary about the service they received at the practice.

The practice participated in Serious Mental Illness Local Enhanced Services (SMILES). The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are currently beyond the scope of essential services. The SMILES services included the management and care of patients with serious mental illness who have been discharged from recovery services at Sussex Partnership NHS Foundation Trust. Their responsibilities included prescribing, monitoring and administration of medication, regular, comprehensive reviews, proactive follow up and comprehensive risk assessment and collaborative care planning. One patient commented that one clinician had been a highly supportive and stabilizing factor in the management of their chronic mental health issues.' Staff told us that they held clinics for patients with mental health issues on Tuesdays and in addition the nurse undertook a lot of home visits.

Staff told us that they used a high number of translators to cater for their non-English speaking patients. The practice manager stated that it was their policy not to use family members as translators.

The practice had a patient participation group (PPG). PPGs are groups of active volunteer patients that work in partnership with practice staff and GPs. This unique partnership between patients and their practices provides a mechanism through which improvements to patient services, experiences and care can be highlighted and

Are services responsive to people's needs?

(for example, to feedback?)

actions decided. We spoke with three members of the group on the day of our visit. They confirmed that the group met regularly throughout the year with a GP and practice manager. A member of the PPG commented that the practice always implemented comments fed back from the PPG and gave the following example: some decorating was undertaken. Another member told us that there had been recent discussion about the possibility of the practice undertaking annual health checks on Saturday mornings and forming a peer support group where patients who are experiencing the same issues could meet on a voluntary basis to support each other.

The practice was innovative in its methods of engaging with their patients. In addition to the usual methods it used their website and text messaging. For example it sent 2900 texts inviting patient to participate in their 2014 patient survey.

Staff told us that if patients needed to have non-clinical private conversations patients were offered the use of a side room to ensure privacy and confidentiality.

Access to the service

The premises were Disability Discrimination Act 1995 compliant. All the facilities, for example the waiting room, treatment room and consultation rooms were on the ground floor. In addition the wash room facilities were modified for use by wheelchair users.

We saw that patients could make appointments in a number of ways, for example via the practice website, by telephone or in person. Patients were made aware of these methods by the website, patient leaflet, and the reception staff. The practice was open for extended hours on a Wednesday. When the practice was closed patients were guided by messages on the practice website, telephone answer machine and notices in the waiting room to telephone Out of Hours for assistance. There were evening appointments available and telephone consultations with a GP. Patients with a medical problem which prevented them from attending the practice were asked to telephone the practice to request a home visit. These patients were also advised that it may not be one of the GPs from the practice who attends but a GP from a practice that they work in partnership with.

Concerns and complaints

The practice had a complaints policy which included instructions to acknowledge the complaint, investigate it and issue a final response that included the contact details which enabled complainants to take the matter further should they wish to do so.

The practice website had facilities for patients to raise and concerns they had. In addition patients were encouraged to discuss any issues with the practice's patient participation group members if they did not want to speak directly to staff members at the practice.

Are services well-led?

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

Summary of findings

The practice was well-led. The management team had developed an open and democratic culture where all staff were able to freely raise issues and concerns. This open culture was instrumental is promoting shared learning between colleagues.

Our findings

Leadership and culture

The practice manager explained that they operated an 'open door' culture in that staff were encouraged to raise any concerns and issues with him and any of the partners. All the administrative staff we spoke with confirmed that to be the case. Most of the staff we spoke with told us that they worked well as a team and felt supported by colleagues and that they shared information and advice freely between themselves. A member of the clinical team told us that everyone feels comfortable around the senior partner and he was incredibly up to date and that they passes his knowledge on to the whole team. Staff we spoke with told us that they felt able to raise any issues at any time including at their monthly meetings. We saw evidence that the practice held monthly meetings which covered numerous and various topics. Within one meeting we were told by staff that they raised concerns about the future of the practice and succession planning.

Governance arrangements

The governance arrangements within the practice included the delegation of responsibilities to named doctors and nurses, for example, a lead for safeguarding, and infection control. This helped to clarify the role of each doctor, and provided structure for staff in knowing who to approach for support and guidance when required.

Governance/management meetings were held on a regular basis to consider quality, safety and performance within the practice. This included monitoring of complaints, comments and suggestions received from patients, issues raised by the patient participation group and staff. Information from the practice Quality and Outcomes Framework (QOF) was analysed and reviewed to enable the practice to make comparisons to national performance and locally agreed targets. For example, we saw evidence that the practice had concentrated particularly on mental health over the last year. Information from clinical audits were reviewed and actions taken to achieve potential improved outcomes for patients.

The GPs had maintained their professional registration with their governing body, the General Medical Council. In doing so they were required to undertake accredited training courses to update or increase their skills and knowledge

Are services well-led?

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

Systems to monitor and improve quality and improvement

The staff we spoke with told us that the practice manager had an 'open door policy' and that they were confident that they could raise any issues with him including whistleblowing concerns. Staff were confident that they would be listen to and treated fairly. All staff we spoke with knew where to locate the practice's whistleblowing policy. However, when we reviewed the policy, we found that it was a statement rather than a fully formulated policy and procedure. There was no formal whistleblowing policy that described the processes that need to be followed when raising a whistleblowing concern and what safeguards and assurances are in place for the whistleblower. We discussed our findings with the practice manager. The provider may wish to note that the lack of a fully formulated whistle blowing policy and procedure meant that there is a risk that staff may not raise whistleblowing concerns which is also a risk for all patients and the practice.

Patient experience and involvement

We saw that engagement with patients was managed through the patient participation group and we spoke with their representatives during the inspection. They told us that management were responsive to suggestions and supported regular patient surveys to consider ways to improve the practice and make changes where it was practicable to do so. We saw examples of where changes had been made in response to comments and feedback received from patients, including changes to improve the environment for patients. Patients also had the opportunity to engage with the practice through their website. We looked at the March 2014 patient survey results and saw that the majority of comments were positive and some of the suggestions had already been implemented within the practice. The practice had an online website containing a dedicated section for the PPG, where recent surveys, meeting minutes and the group's annual report could be accessed by patients and members of the public. There was also a facility to access an online survey form where feedback and comments could be submitted.

Staff engagement and involvement

Staff were encouraged to attend and participate in regular staff meetings and we saw evidence that regular meetings took place to include discussions about changes to procedures, clinical practice, and staff cover arrangements.

We saw that the practice openly discussed significant events at these meetings, shared their learning and explained the actions required to reduce the risk of them recurring.

Staff were aware of the practice's whistleblowing policy and where to find it. However, it did not explain the whistleblowing process in detail. For example it did not provide the contact details of external authorities if staff wished to report concerns outside of the practice or explain what they could expect to happen or any safeguards staff would be afforded throughout the process.

We saw that the practice maintained a training matrix that showed staff names, the training they had received and the date it took place. The matrix included training on computer systems, annual infection control training, a frailty workshop and annual cardiopulmonary resuscitation training. Staff we spoke with confirmed that they had undertaken the training.

We saw evidence, which was supported by staff comments, that they received annual appraisals to review their performance and to identify additional or ongoing learning needs. Most of the staff we spoke with said that they felt well supported by the practice. They described the practice as having an 'open door policy' where they felt they could raise any issues or concerns freely with the management at any time.

Learning and improvement

The practice manager explained that staff were encouraged to raise any issues about the practice with him or other members of the management. One member of staff commented that they felt comfortable that the management would listen to any issues raised and act upon them. Staff also told us that senor clinical staff would share ideas and learning at the regular staff meetings. The practice manager also explained that they improved patient outcomes my constantly focussing on patient needs to determine the care they are offered.

Identification and management of risk

We saw that systems and processes were in place to manage risks. For example assessments were undertaken to consider and determine likely risks to business continuity by disruption to or the loss of the premises. The practice manager explained that currently there was no succession plan in place but they were in the process of formulating a two year plan to take into account

Are services well-led?

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

forthcoming changes. For example, their building lease was due to lapse in four years' time, the imminent retirement of key members of staff and projected staff absences. To ensure the continuity of the practice and the continuity of care for their patients one GP told us that they had recently attended a meeting to discuss the concept of becoming part of a Federation of GP practices.

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

We had some concerns about the safety of services provided at the practice for older patients.

We had some concerns that there was not a safeguarding policy to support vulnerable adult/older people.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also present a risk to patients.

We found that the practice had a good recruitment policy and appropriate professional/safety checks had been carried out when staff were recruited. For example we saw that the practice took up the references provided.

The practice offered annual flu vaccinations routinely to older people to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered to older people for example all patients over seventy-five had a named GP and a care plan. The practice was responsive in meeting the needs of older people and in recognising future demands in service provision for this age group. The practice was well-led in relation to allocating a named lead GP to each patient in this population group and channelling its resources and efforts to the particular demographics of patients who are registered with them.

Our findings

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

We had some concerns about the safety of services provided at the practice for patients with long-term conditions.

We had some concerns that there was not a safeguarding policy to support adults/patients with long-term conditions. The practice had a safeguarding policy that reflected the arrangements for protecting children from the risks of abuse.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also present a risk to patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

The practice offered annual flu vaccinations routinely to people with long-term conditions to help protect them against the virus.

We found the practice to be caring in the support it offered to patients with long-term conditions and that the care provided was satisfactory, treatment pathways were monitored and kept under review. The practice was responsive in prioritising urgent care that people required and the practice was well-led in relation to improving outcomes for patients with long-term conditions and complex needs.

Our findings

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

We had some concerns about the safety of services provided at the practice for mothers, babies, children and young people.

The practice had a safeguarding policy that reflected the arrangements for protecting children from the risks of abuse. They also had a safeguarding lead This meant that staff were able to recognise or have awareness of the risks of abuse for vulnerable children.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

The practice offered annual flu vaccinations routinely to mothers to help protect them against the virus.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for babies, children and young patients.

We found that the practice was responsive to patients who know that they are pregnant by asking them to make an appointment to see their GP.

Our findings

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

We had some concerns about the safety of services provided at the practice for working age patients.

The practice had a safeguarding policy that reflected the arrangements for protecting children from the risks of abuse. But they did not have a policy for vulnerable adults.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

The practice offered annual flu vaccinations routinely to patients at risk to help protect them against the virus.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for working age patients.

We found the practice to be caring in the support it offered to working age and recently retired patients, and were responsive in reviewing opening hours.

Our findings

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

We had some concerns about the safety of services provided at the practice for people in vulnerable circumstances who may have poor access to primary care.

We had some concerns about the lack of staff training in safeguarding vulnerable adults.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

The practice offered annual flu vaccinations routinely to people who may be vulnerable and at greater risk, to help protect them against the virus.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for patients in vulnerable circumstances who may have poor access to primary care.

We found that the practice was caring about vulnerable patients, in particular, the premises were accessible and suitable for patients with reduced mobility. There was effective support from the practice for vulnerable people in the community and the practice was responsive in providing care and treatment at patients' homes who found it difficult to attend the practice.

Our findings

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

We had some concerns about the safety of services provided at the practice for people experiencing poor mental health.

We had some concerns that there was not a safeguarding policy to support adults/older people.

The practice did not have a comprehensive whistleblowing policy. This meant that there was a risk that concerns may not be raised appropriately which may also be a risk to patients.

The practice offered annual flu vaccinations routinely to people who may be vulnerable and at greater risk, to help protect them against the virus.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out.

There were systems and procedures at the practice to ensure that information received from other service providers was used to improve safety for patients in vulnerable circumstances who may have poor access to primary care.

We found the practice had a caring approach to patients who may be experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments, and were responsive in referring patients to specialist service providers for ongoing support. Management provided a satisfactory approach in relation to identifying and managing risks to patients who may be experiencing poor mental health.

Our findings

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **This regulation was not being met because the practice did not have safeguarding policies in place in respect of vulnerable adults to ensure staff understood the signs of abuse and how to effectively report concerns.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **This regulation was not being met because the practice did not have an effective whistleblowing policy for reporting where the service falls below essential standards of quality and safety.**