Brighton Homeless Healthcare

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.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brighton Homeless Healthcare on 12th May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the care of all the population groups and we saw an element of outstanding practice in relation to care of people in vulnerable circumstances who may have poor access to primary care.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to legionella re-inspection and undertaking regular fire drills.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice held multidisciplinary team meetings weekly at the local hospital and fortnightly with local homeless hostels to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, those with end of life care needs or children on the at risk register).

However there were areas of practice where the provider needs to make improvements.

The provider should;

- Should ensure risk assessments and action plans are followed such as the frequency of legionella inspection.
- Ensure regular fire drills are undertaken.
- Ensure access to the practice is within the contractual opening times of 8am to 6.30pm.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Brighton and Hove Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and

Summary of findings

meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of Accident and Emergency attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, when patients had secured regular employment and were no longer homeless, the practice

would support them to transfer to another practice in their community while providing an on-going service to ensure continuity of care. The practice was proactive a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. All patients within the practice were living in vulnerable circumstances and were either street homeless, in temporary housing or part of the travelling community. It offered longer appointments for all patients and provided both appointment and walk in services to meet the needs of the population group.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and worked collaboratively to provide outreach in the community in ways that would make it easier for vulnerable patients to access the service. It had told vulnerable patients about how to access various support groups and voluntary organisations and frequently worked together with these organisations to meet patient needs. It worked proactively to identify reasons for difficulties vulnerable patients had in accessing services and took action to address this, for example running dedicated clinics for women and providing outreach services. Staff knew how to recognise signs of abuse in vulnerable adults and children and they had systems in place to address concerns. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 100% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and those requiring substance misuse services. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended Accident and Emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

Patients told us they were satisfied overall with the practice. Comments cards had been left by the Care Quality Commission (CQC) before the inspection to enable patients to record their views on the practice. However, none of these were completed. Staff told us they had encouraged patients to provide feedback but that this was difficult because of the nature of issues many patients faced including homelessness, poor physical health, poor mental health and addiction problems. We spoke with five patients on the day of our visit.

We reviewed the results of the national patient survey which contained the views of 24 patients registered with the practice. The national patient survey showed patients were generally pleased with the care and treatment they received from the GPs and nurses at the practice. The survey indicated that 100% of patients with a preferred GP usually got to see or speak to that GP, 100% had confidence and trust in the last nurse they saw or spoke to and 96% had confidence and trust in the last GP they saw or spoke to.

We spoke with five patients on the day of the inspection. The patients we spoke with were positive about the service they received. We were told there was good quality and continuity of care and that staff were kind and caring. Patients told us they were very happy and one patient in particular told us the practice had helped to improve their health and take better care of themselves.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Continue to look at systematic ways of engaging with patients about the services provided and ensure that these are recorded and evaluated.
- Ensure regular fire drills are undertaken.
- Ensure access to the practice is within the contractual opening times of 8am to 6.30pm.

Outstanding practice

- The practice held multidisciplinary team meetings weekly at the local hospital and fortnightly with local homeless hostels to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, those with end of life care needs or children on the at risk register).

Brighton Homeless Healthcare

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Brighton Homeless Healthcare

Brighton Homeless Healthcare offers specialist GP services to homeless patients in Brighton and Hove. There are approximately 1300 registered patients.

The practice is run by The Practice Group. The practice was supported by central management functions from the head office, including human resources, health and safety and clinical locality leads. The practice was also supported by two GPs, including one who was regional clinical lead for The Practice Group, two nurses, and a team of receptionists. Operational management was provided by the practice manager and the assistant practice manager.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks, wound care, a substance misuse service and weight management support.

Services are provided from:

Brighton Homeless Healthcare

Morley Street

Brighton

BN2 9DH

The practice has opted out of providing Out of Hours services to their patients. There are arrangements for patients to access care from an Out of Hours provider.

The practice population has a higher percentage of patients with a long standing health condition (90%) and those with health related problems in daily life (89%) compared with the England and CCG average. The practice population also has a higher number of patients claiming disability allowance compared with the England and CCG average, plus a significantly higher percentage of unemployment and a lower percentage of patients in paid work or education.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting we reviewed a range of information we hold about the practice and asked other organisations such has Brighton and Hove Clinical Commissioning Group and Health watch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practice website and carried out an announced visit on 12 May 2015.

We talked with all the staff employed in the practice who was working on the day of our inspection. This included one GP, two practice nurses, two administrative staff, the practice manager and assistant practice manager. We spoke with five patients visiting the practice during our inspection.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with was aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we saw that incidents were reported on the practice electronic system that all staff had access to and had used.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of two significant events that had occurred during the last year and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated quarterly meeting was held centrally by the Practice Group to review actions from past significant events and complaints across the group. Trends and issues identified from this process were then cascaded back to practice staff. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. One particular example we saw was an incident regarding the behaviour of a patient where discussions had been recorded in the minutes of a practice meeting and had led to changes in the practice violence and aggression policy. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager electronically to practice staff and received directly by the practice GP. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us relevant alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice GP was the dedicated as lead in safeguarding vulnerable adults and children. They and the lead practice nurse had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. All staff we spoke with were aware who these lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and children thought to be living in vulnerable circumstances were considered to be potentially at risk. We viewed a standard referral protocol where local safeguarding teams would be alerted to any

child brought into the surgery. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had had a criminal records check via the Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. Staff were able to give us examples of action that would be taken if there were concerns about the suitability of medicines for use, including contacting the manufacturer for advice and taking medicines out of circulation. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. Specifically, we saw that an audit of potentially dangerous medication had been shared and discussed and that a search had been designed for on-going review of risky medicines.

There was a system in place for the management of high risk medicines, and disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked six anonymised patient records which confirmed that the procedure was being followed.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in the preceding months. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Good

Are services safe?

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, in relation to wound management and the use of sterile dressing packs and waste disposal processes. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were generally completed on time. We saw that the infection control lead had requested elbow taps for the sink in the nurses' treatment room as these had been replaced with standard taps by the estates team responsible for the building. We viewed records of this request having been followed up by the practice. Minutes of practice meetings showed that the findings of the audits were discussed.

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

The trust who owned and managed the building in which the practice operated had carried out testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed this had been carried out on 19 December 2012but the practice did not have records to demonstrate that an annual re-inspection had been carried out in line with the risks assessed and the recommendation of the initial report.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which had been in the preceding 12 months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate criminal records checks via the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We saw that locum doctors would be used to cover the lead GP and we saw a detailed locum pack in place and appropriate checks had been carried out.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always

Good

Are services safe?

enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Examples of risk assessments we viewed included fire safety and the risk of violence and aggression. The meeting minutes we reviewed showed risks were discussed at practice and team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia The practice also held in stock treatment used to reverse the effects of narcotic drugs. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, loss of the telephone system, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, arrangements were in place and contact details available for The Practice Group Facilities manager and key contacts for the estates department responsible for the building. The plan was last reviewed in 2014.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training although they did not practise regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GP told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions that meet the needs of their practice population. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their

records and that their needs were being met to assist in reducing the need for them to go into hospital. The practice would work closely with other agencies to engage with patients who were considered to be at risk of admission.

We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. Specifically, we saw that the practice nurse attended multidisciplinary pathway meetings at the local hospital where all registered patients who have had a hospital admission would be discussed. The lead GP would review all patients following a hospital admission.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and nursing staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us five clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, in response to low uptake of cervical smears the practice had undertaken an audit, including seeking feedback from patients as to why that may be. As a result the practice had implemented strategies for increasing uptake. A subsequent follow up audit demonstrated a small increase in uptake and we viewed further plans for on-going improvements in this area.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of

Good

Are services effective?

(for example, treatment is effective)

preventative measures). For example, we saw an audit regarding the prescribing of potentially high risk medication. A search had been designed for this high risk medication review each month and we saw that GPs carried out regular medication reviews on patients taking these medicines. Action included requesting specialist review and ensuring that regular blood tests and other tests were being carried out routinely. and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 92.6% of the total QOF target in 2014, which was similar to the national average of 93.5%. Specific examples to demonstrate this included:

- Performance for asthma related indicators was better than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average
- Performance for mental health related and hypertension QOF indicators was better than the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example, cervical screening uptake was below the CCG and national average and we saw that this had been audited and action had been taken, resulting in some improvements. We viewed actions plans for continual reviews and activities to improve uptake in the long term.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GP had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. The nature of the practice population meant that all patients were identified as being vulnerable, for example homeless people and travellers. Structured annual reviews were also undertaken for people with long term conditions (e.g. Diabetes, COPD, Heart failure). However, we saw that the practice operated these opportunistically and in line with other care providers to ensure they captured patients who may not routinely attend the practice. For example, we saw that the practice nurse ran clinics at city based drop in centres and voluntary sector organisations. We also saw that the practice was represented at multidisciplinary meetings held at the local hospital and homeless hostels within the city.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Good

Are services effective?

(for example, treatment is effective)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the practice nurse had undertaken a substance misuse module and was undertaking nurse practitioner training.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, a member of the reception team was also being trained to take on additional healthcare assistant duties. This included phlebotomy and new patient health checks. Those with extended roles (add in example e.g. seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease) were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out-of-Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice was represented at weekly hospital pathway meetings where all patients who had been admitted to hospital would be discussed and the GP reviewed all discharges on a weekly basis.

The practice held multidisciplinary team meetings weekly at the local hospital and fortnightly with local homeless hostels to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses, voluntary sector workers and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and Out-of-Hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also developed a number of pathways with other providers to improve communication and information sharing. For example, they had improved links with the local Pathway Team, providing enhanced care co-ordination for homeless people admitted to hospital.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. For example, the practice nurse told us how they were involved in a patient's hospital care to support best interest decisions when the patient had a deterioration in their mental capacity. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, verbal consent was sought for taking photographs of wounds to share with the tissue viability nurse. Written consent was sought for the use of a high potency vitamin B supplement that required the patient to attend the surgery every day for a few days. We saw that consent was documented in the patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

Staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice worked closely with other providers of care services for people who are homeless and through this, identified health and social care needs of patients while working collaboratively to meet these needs.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the practice staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation and general health and wellbeing advice. We also saw that the practice had been involved in the ongoing development of a TB pathway for homeless persons in Brighton.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients if they had risk factors for disease identified at the health check and how further investigations were scheduled. We saw that this involved working closely with other agencies and key workers involved in the patient's care to ensure as much was done as possible to encourage patient's to attend appointments.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 72% patients over the age of 16 and actively offered nurse-led smoking cessation clinics to all of these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 55%, which was below the national average of 81%. The practice had undertaken a patient survey to identify reasons for the low uptake of cervical smears. This had resulted in the practice providing a service run by a female GP and nurse and providing patients with hygiene facilities as poor hygiene facilities had been a significant reason for many women not accessing the service. The practice had also run evening pamper sessions in collaboration with other services to improve uptake and focus on women's health. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

Good

Are services effective?

(for example, treatment is effective)

- Flu vaccination rates for the over 65s were 25%, and at risk groups 36%. These were below national averages.

The practice had a process for 6 monthly audits of children registered at the practice to monitor actions regarding follow up and uptake of immunisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015.

The evidence showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% said the GP was good at listening to them compared to the CCG average of 86% and national average of 87%.
- 89% said the GP gave them enough time compared to the CCG average of 84% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 91% and national average of 92%.
- 91% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 79% and the national average of 79%.
- 91% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 79% and the national average of 80%.
- 100% said they had confidence and trust in the last nurse they saw compared to the CCG average of 85% and the national average of 85%.

We left CQC comment cards at the practice for the two weeks preceding our inspection. The comment cards enabled patients to comment on aspects of the practice such as cleanliness, the service they received and their experience of the staff at the practice and if they were treated with dignity and respect. No comment cards had been completed at the practice. Staff told us they had tried a number of ways to engage with patients in terms of seeking feedback about their satisfaction with the practice but that this had been difficult due to the nature of the practice population. Past efforts to gain feedback by the practice had included attempting to set up a PPG (patient participation group), satisfaction surveys and the use of a white board in the reception area for patients to write comments.

We spoke with five patients on the day of our inspection. All patients who accessed the service were vulnerable due to them being street homeless, temporarily housed or from the travelling communities. Patients consistently told us that staff communicated with them with care and compassion and without judgement. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk. The reception desk was by a glass partition as a safety measure due to issues the practice had experienced with violent and aggressive patients, however this made it difficult for patients to be heard when speaking to reception staff. This meant that confidentiality was difficult to maintain when staff were speaking with patients at the reception area. The practice manager had sourced quotes from contractors to replace the glass so patients and staff could communicate more easily and confidentially. In the meantime, staff were able to speak to patients individually away from the reception area if confidentiality was an issue. We observed reception staff being mindful of patient confidentiality. Additionally, 89% of patients said they found the receptionists at the practice helpful which was comparable to the CCG average of 87%.

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

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 83%.
- 89% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 75%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 83%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 77% and national average of 78%.

The patients we spoke with on the day of our inspection were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. The nature of the patient population meant that sometimes staff were unable to contact family members because they did not have contact details of any family members. Staff told us that learning from a recent experience had identified the need to ask patients if they had family members they would want to be contacted should the need arise. We saw that bereavement support training was being sourced for a staff member where this was identified as part of an appraisal and personal development plan.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the practice held walk in clinics twice a day for patients in addition to pre-booked appointments. This was in response to patients struggling with keeping pre-booked appointments and poor attendance within the practice. Patients we spoke with told us the walk in clinic worked well for their needs.

Patients experiencing poor mental health were supported by the GP and local mental health teams. Patients with likely dementia were offered an regular review. The practice worked closely with the Mental Health Homeless Team and the local substance misuse service. The practice also provided a nursing outreach service where the practice nurse would hold sessions each week in local services that supported patients who were homeless, had poor mental health and sometimes substance misuse issues.

The practice supported patients with either complex needs or who were at risk of hospital admission. The practice told us they worked closely with community teams to support patients who found it difficult to attend hospital. For example the practice had close links with respiratory, heart failure and diabetes teams within the community. The practice was involved in a hospital based multidisciplinary team meeting that was part of a pathway to support homeless patients. The practice had a palliative care register and had regular internal discussions to support patients. The GP attended regular Gold Standard Framework meetings. The practice had successfully supported two patients in the preceding two years who had received palliative care while living in a city based homeless hostel. The GP told us this experience had created an opportunity to learn how best to support palliative care patients who are homeless. The practice has also worked closely with local hospices and nursing homes to provide support for palliative care patients.

Patients with a long term condition had their health reviewed in one annual review where possible but also identified opportunistic ways of working collaboratively with other community and voluntary agencies to ensure patients were reviewed regularly to proactively manage their health as much as possible. The practice provided care plans for asthma, chronic obstructive pulmonary disease (COPD), coronary heart disease, diabetes, dementia and severe mental health.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, although this was specific to the nature of providing a service for homeless patients. For example, longer appointment times were available for all patients due to the vulnerability of the patient group as a whole. The practice worked closely with other local organisations to provide a service for patients from vulnerable groups. For example, street homeless, those in temporary housing, the travelling community, those with substance misuse problems and those with mental health problems. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they would register patients who were of "no fixed abode" and would see someone if they came to the practice asking to be seen. The practice nurse provided an outreach service where they would hold sessions at local community projects. She told us she would take new patient registration forms with her and support new patients to register with the practice as needed. There was a system for flagging vulnerability in individual patient records.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 9am to 5pm Monday to Friday. Appointments were available from 9 am to 5 pm on weekdays. Phone calls to the service were directed to an on call GP outside of these times, there was telephone access from 8am to 6.30pm. The practice ran earlier and later appointment times depending on patient need. On the day of our inspection we saw that the GP was seeing patients from 8 am. The practice operated a twice daily walk in clinic as this had been identified as a successful way of managing appointments was the practice population group.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the Out-of-Hours service was provided to patients.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 85% were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 83% described their experience of making an appointment as good compared to the CCG average of 76% and national average of 74%.
- 68% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 68%.
- 97% said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 72%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could routinely see a doctor on the same. Routine appointments were available for booking in advance, however because of the specific needs of the population group appointments in advance were not often used. Comments received from patients also showed that patients in urgent need of treatment had always been able to make appointments on the same day of contacting the practice. For example, we spoke with a patient who had experience of attending the surgery and being seen on the day.

Many of the patients' circumstances made them vulnerable and we saw that the practice worked in partnership with them and other local services to meet people's needs. All patients were offered longer appointments and GPs would be flexible in offering appointments earlier or later in the day if needed. Staff would also see patients via an outreach service if they found it difficult to attend the practice. The practice had made efforts to meet the needs of those in hard to reach groups by working collaboratively with other services in the local community.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of information on the notice board in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice manager told us that while they had taken steps to inform patients of how to raise a concern or complain should the need arise, they had not received any complaints relating to the practice. They told us this was largely due to the nature of the practice population group, in that if a patient had a concern it was generally raised in person at the time. They told us this would sometimes be recorded as an incident rather than a complaint if the patient had behaved in a way that was challenging. However, we saw that when an incident was recorded as a result of a patient being unhappy, the cause of the incident would be explored, recorded and discussed at practice meetings with a view to identifying lessons learned.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints annually along with significant events to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. There was a clear objective to address social inequalities and ensure that a vulnerable group of men and women, often with high morbidity and mental health needs, received good access to primary health care and onward referral. We saw evidence the aims and objectives of the practice were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room.

We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a number of these policies and procedures, including consent, chaperone policy, equality and diversity, health and safety, staff recruitment, complaints and whistle blowing. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. They included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing above or in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, audits of high risk medication, enhanced services and children registered at the practice. The practice also undertook regular surveys, including staff understanding of the Mental Capacity Act 2005 and its application in practice. Evidence from other data from sources, including incidents was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice was continually reviewing patient satisfaction processes to capture the views of patients who may not typically share their views in standard formats such as survey questionnaires. The practice regularly submitted governance and performance data to their central office and to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example their violence and aggression risk assessment and subsequent policy. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Are services well-led?

Good

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

The GPs and management (including local and regional managers and clinicians) were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the leads encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had attempted a number of methods for gathering feedback from patients, including the development of a PPG and the use of a white board in the waiting area for patients to records comments on the day of their appointment. There had been limited success in these methods and the practice had not been able to develop an active PPG due to the vulnerability of the patient group. However, examples of where some success had been achieved included seeking feedback from patients about a dedicated women's service and where staff had held face to face discussions with patients about their views.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example they had reviewed their violence and aggression policy and involved staff in its development.