Charter 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

Charter Medical Centre is located in Hove and provides primary care medical services to approximately 17400 patients in the locality. The practice has eight general practitioners (GPs), all of whom form the partnership management team as the registered provider of services at the practice. The practice is also a training practice for GPs and paramedic practitioners. The services are governed by the Brighton and Hove Clinical Commissioning Group (CCG) and provide regulated activities for Diagnostic and Screening Procedures, Treatment for Disease, Disorder and Injury, Family Planning, Surgical procedures, Maternity and Midwifery.

We spoke with nine 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 comment cards prior to our inspection, most 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 the patient satisfaction survey undertaken in March 2014 that showed patients were consistently pleased with the service they received.

We spoke with various members of the clinical team including four GPs, an Advanced Nurse Practitioner, two Nurses and a Phlebotomist and a Health Care Assistant, the Practice Manager and five of the non-clinical staff on duty. They told us that the management were open and approachable and that there was good team working amongst all the staff at the practice. 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.

The practice address is Charter Medical Centre 88 Davigdor Road Hove East Sussex BN3 1RF

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the service was safe. The practice had good policies and procedures that included environmental cleaning, infection control, safeguarding children and vulnerable adults. Staff we spoke with demonstrated an awareness of those processes and applied them. Care and treatment was provided to patients in a clean and safe environment.

Are services effective?

Overall, 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. Patients were also offered details that gave them the opportunity to access information about adopting healthy lifestyles and choices, advice about physical signs to be aware of that need their GPs attention and help with seeking out assistance from other services.

Are services caring?

Overall, patients experienced a caring service. The comments we received were mostly positive. The practice's March 2014 patient survey showed that the majority of patients said that the service was excellent or very good.

Are services responsive to people's needs?

Overall 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 and Virtual Patient Reference Group which the practice had set up to channel suggestions to the management team. In addition patients could raise issues with the practice in various other ways including in person or through the practice website. We saw evidence that changes had taken place as a consequence of patient feedback.

Are services well-led?

Overall the practice was well-led. The management team developed an open culture where all staff were able to freely raise issues and concerns. This open culture was 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 no concerns about the safety of services provided at the practice for older patients.

Staff had received training in safeguarding vulnerable adults/older patients. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for vulnerable adults/older patients.

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all patients.

We found that the practice had a robust 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 doctor to each patient in this population group and channelling its resources and efforts to the particular demographics of patients who were registered with them.

People with long-term conditions

We had no concerns about the safety of services provided at the practice for patients with long-term conditions.

Staff had received training in safeguarding children and vulnerable adults/older people. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for children and vulnerable adults/older patients.

Summary of findings

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all 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 effective, 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 no concerns about the safety of services provided at the practice for mothers, babies, children and young people.

Staff had received training in safeguarding children and vulnerable adults/older people. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for children and vulnerable adults/older patients.

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all 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 doctors.

Summary of findings

The working-age population and those recently retired

We had no concerns about the safety of services provided at the practice for working age patients.

Staff had received training in safeguarding children and vulnerable adults/older people. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for children and vulnerable adults/older patients.

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all 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. We had no concerns about the safety of services provided at the practice for people in vulnerable circumstances who may have poor access to primary care.

Staff had received training in safeguarding children and vulnerable adults/older people. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for children and vulnerable adults/older patients.

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all 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.

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 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 in vulnerable circumstances who may have poor access to primary care

We had no concerns about the safety of services provided at the practice for people in vulnerable circumstances who may have poor access to primary care.

Staff had received training in safeguarding children and vulnerable adults/older people. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for children and vulnerable adults/older patients.

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all 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.

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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.

Summary of findings

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 no concerns about the safety of services provided at the practice for people experiencing poor mental health.

Staff had received training in safeguarding children and vulnerable adults/older people. The practice had a safeguarding policy that reflected the arrangements for protecting children and vulnerable adults/older patients. These policies were available to all staff from a desk top link on their computers, for ease of access. This meant that staff were able to recognise or have awareness of the risks of abuse for children and vulnerable adults/older patients.

The practice also had a comprehensive whistleblowing policy that staff were aware of. This meant that any concerns about the practice or colleagues could be raised appropriately which is a benefit to all 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 well-led 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 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 MUST take to improve

The practice must undertake a risk assessment to identify and manage potential risks in relation to those staff that had contact with patients but had not undergone security checks.

Action the service COULD take to improve

The practice could undertake formal non-clinical supervisions of their staff.

The practice could update their details for external contacts in the whistleblowing policy.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was innovative in its methods of engaging with their patients. For example it took the initiative to engage with the local Greek community by holding meetings to discuss health issues, in particular diabetes. In addition, the practice and the PPG used social media, which helped them reach Polish youth in the community as it is a format of communication favoured by them.

The touch screen booking in facility was available in four languages other than English. As such the practice was better able to maintain patient confidentiality for their culturally diverse patient population group when patients were accessing or receiving a service from the practice.

Charter 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 a clinical lead. The team also included a CQC inspector and one specialist advisor in practice management.

Background to Charter Medical Centre

The practice is located in Hove. It is an eight doctor partnership. The practice is regulated to provide Diagnostic and Screening Procedures, Treatment for Disease, Disorder and Injury, Family Planning, Surgical procedures, Maternity and Midwifery. They provide NHS services for approximately 17,400 patients in the locality. Their patients come from wide ethnic, cultural and social backgrounds.

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

The practice address is Charter Medical Centre 88 Davigdor Road Hove East Sussex BN3 1RF.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 4 June 2014. During our visit we spoke with a range of staff. Our GP clinical lead and inspector spoke with GPs and the advanced nurse practitioner. The practice manager specialist spoke with the practice manager. The lead inspector spoke with the health care assistant, phlebotomist and patients. The inspector spoke with administrative staff, representatives of the Patient Participation Group (PPG) and patients. We reviewed 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

Detailed findings

with us. We also observed how patients were supported by reception staff before they were seen by members of the clinical team. We used those methods to gather information from people who used services and staff.

Are services safe?

Summary of findings

Overall the service was safe. The practice had good policies and procedures that included environmental cleaning, infection control, safeguarding children and vulnerable adults. Staff we spoke with demonstrated an awareness of those processes and applied them. Care and treatment was provided to patients in a clean and safe environment.

Our findings

Safe patient care

Patients accessed the practice via the main steps from the public path or an adjacent ramp. A lift was located in the underground car park for those patients with mobility problems. On the day of our inspection we saw the clinical and public areas, some treatment/consulting rooms, the waiting room, stairwell, corridors and reception and we observed that these areas were clean and tidy. A representative of the Patient Participation Group (PPG) we spoke with told us that there were no cleanliness issues. We noted that clinical waste was securely stored under lock and key prior to collection by a regulated waste collector for safe disposal. This meant that the provider had taken steps to reduce the risk of infection to patients, visitors and staff.

Learning from incidents

The practice manager explained that they held clinical meetings on alternate Wednesdays where safeguarding is a permanent agenda item, and all incidents are discussed and the information is shared within the practice. We saw minutes of some of those meetings that confirmed this to be the case. Staff told us that they were encouraged to report significant adverse events which were treated as opportunities to learn and to introduce and apply mechanisms to reduce the likelihood of recurrences. Staff described the practice as having a learning culture which encouraged openness. This meant that all patients were better protected from harm because the practice discussed safeguarding and significant adverse events openly with staff, addressed the issues raised and shared the learning.

Safeguarding

We saw that the practice had safeguarding policies for both children and adults that were provided by Brighton and Hove Clinical Commissioning Group (CCG) and they were accessible to all staff from a desktop link on their computers. The staff training records showed that all staff had been trained appropriately to Levels1, 2 or 3 and they were all up to date with their training. In addition all staff we spoke with confirmed that they had received safeguarding training. They were also able to describe the signs to look out for that would indicate that there is a safeguarding issue that needs addressing. We were given the following example. Administrative staff noticed that a

mother was registered at the practice but not her child. The practice raised a safeguarding alert and as a consequence, the child now has a dedicated social worker. We saw evidence that showed staff undertook mandatory annual refresher courses in safeguarding children and vulnerable adults which were conducted by a company approved by the CCG. This means that the practice had safeguarding policies, a commitment to keeping their staff up to date with their safeguarding training for the benefit of their patients.

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

Monitoring safety and responding to risk

Staff told us that there was a good skills mix of very experienced staff at the practice. One patient commented that they had confidence in the skill of the staff and their knowledge to recognise symptoms.

The practice manager told us that they used locum GPs where necessary to maintain staffing levels to meet their needs. We were also told that the practice, in response to patients requests had decided to open on a Saturday, and they had developed a business case which has been sent to the CCG asking them if they will fund the extra hours.

The practice had a dedicated emergency room which included emergency drugs, oxygen and masks and a defibrillator. We saw that the emergency drugs were within their expiry dates.

Medicines management

The provider had a designated member of staff who kept a record of the medicines in the practice and each quarter they did a visual check and validation of them. Staff explained that they operated a stock rotation process to reduce the likelihood of medicines passing their expiry dates being used. If medicines were due to pass their expiry dates the following quarter they were replaced. We saw that logs were kept to record the daily temperatures of the locked refrigerators that were solely used to store medicines and vaccines. We noted that all the medicines stored in the refrigerator were in date. Staff also explained that they had a process in place to ensure that the cold chain was maintained for those medicines that needed refrigeration. This meant that the practice had reduced the risk that patients would receive medicines and vaccines that had not been stored at the recommended temperature or that had passed their expiry dates.

Cleanliness and infection control

We saw that the practice had an infection control policy which included a range of procedures and protocols for staff to follow, for example, hand washing, handling specimens, clinical waste, needle stick injuries, and personal protective equipment. The practice had an Infection Control Lead (ICL). We saw the practice undertook regular unannounced infection control audits, action plans were created and activities tracked to ensure actions had been completed. This meant that the practice could assure itself that the audits reflected the day to day reality and take effective action to address issues raised, to the benefit of patients/staff.

The practice had policies and mechanisms for the safe storage, handling and transporting of laboratory specimens. For added safety blood test specimens were stored in a dedicated refrigerator. The specimens were collected six times each day by courier. This meant 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 recorded the status of their clinicians Hepatitis B vaccinations. We saw that all the clinicians were recorded as having appropriate protection against contracting Hepatitis B. This meant that staff and patients were at a reduced risk of contracting and spreading Hepatitis B.

The practice manager explained that all staff were required to undertake mandatory annual infection control training. The staff training records we reviewed confirmed that this training took place. This meant that patients were being cared for by staff that had up to date knowledge of infection control procedures.

Staffing and recruitment

We looked in detail at the personnel files for two members of staff, an established member of staff and a new member. We saw that the new employment checklist was comprehensive which included, taking up two references, seeing photographic identification, ensuring occupational health clearance and applying for and receiving a Disclosure and Barring Service (DBS) enhanced check. The

practice manager stated that all clinicians are required to have DBS checks and that an existing check is not accepted. The practice always obtained a new one. The practice manager explained that clinical staff were allowed to see patients before the DBS checks had been completed. Any patients who were flagged up as vulnerable were excluded from that clinician's case load. The practice manager was the only member of the non-clinical team that had a DBS (enhanced) check. We discussed these last two points with the practice manager. They explained that the requirement for a DBS check and the level of that check depends on the roles and responsibilities of the job and the type of contact with vulnerable patients. The practice needed to demonstrate that they had undertaken a risk assessment or decision process to allow a member of staff to work without having received an acceptable DBS check. It is clear from the evidence that a risk assessment or decision process had been undertaken in respect of the clinical staff. However, there were no similar risk assessments or decision processes in respect of non-clinical staff that had contact with patients, for example chaperones, for which they do not hold a current security check from the DBS.

Dealing with Emergencies

The service had spillage kits available, personal protective equipment such as aprons, gloves and goggles for use when necessary .We saw from the training records that all staff had received annual basic life support training that included cardiopulmonary resuscitation (CPR) which was provided by an external CCG approved organisation.

The practice had a dedicated emergency room situated on the ground floor. It had a couch and emergency equipment such as oxygen, emergency drugs and defibrillator. We checked the emergency medicines and found them all to be within their expiry dates. We also saw training records that showed all staff had received training in basic life support training and that it was up to date. Staff we spoke with knew where the emergency room was located and the emergency equipment. This meant that the provider had facilities and trained staff to respond to medical emergencies at the practice.

The practice had a comprehensive 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 plan also contained details of who to contact in the event of an electrical or water failure and other agencies that can provide assistance. The practice had reciprocal arrangements with three other general practices nearby to provide support.

Equipment

We saw records of tests that were carried out on portable electrical equipment to ensure they were safe to use. They were last tested in March 2014 We saw records that showed fire equipment was regularly maintained and serviced. We also saw records of maintenance and calibration of a range of equipment that was in daily use at the practice. They were last tested in January 2014.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall, patients experienced an effective service. There were measures in place to monitor the delivery of treatment. Clinical audits, reviews and multi-disciplinary working were used to improve outcomes for patients. Patients were also offered leaflets and booklets that gave them the opportunity to access information about adopting healthy lifestyles and choices. Some leaflets included advice on symptoms to be aware of that need drawing to the attention to their GP and what other health and social care services were available.

Our findings

Promoting best practice

All the teams and the Patient Participation Group (PPG) held regular meetings that were recorded. For example, the practice manager held fortnightly meetings to cascade information from the various meetings to heads of each department who cascaded that information to front line team members. We saw the agenda and minutes of meetings that went back six years. This demonstrated a consistent, coordinated and sustained approach to sharing information and best practice throughout the practice.

We spoke with clinical staff who told us that patients needs and potential risks were assessed at initial consultations with clinicians. Where required individual clinical and treatment pathways were agreed with the patient and recorded on the patients' computer record. One clinician commented that they would create a joint treatment plan with colleagues if there were ethical issues to address in the provision of care or treatment.

We were told that all staff were issued with mental capacity documents and information. Staff we spoke with confirmed this and were able to demonstrate an awareness of the rights of patients who lacked capacity to make decisions and give consent to treatment. We saw evidence that the practice had protocols for the consent to treatment and a form was used to gain written consent of patients undergoing specific treatments, for example, contraception.

All GPs had access to the on-line NHS information services which enabled them to receive and access up-to-date information.

Management, monitoring and improving outcomes for people

The practice manager told us that they use the Quality 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. The practice used the information provided by QOF to review the effectiveness of some of the treatments provided to patients. In addition the practice used a patient recall system to identify patients from the

Are services effective?

(for example, treatment is effective)

QOF data that required multiple disease checks. Consequently patients were called for a consultation to discuss a number of issues. This meant that the practice was being more efficient with the use of the patient's time and clinical time.

The practice had nominated clinical leads for QOF outcomes and where shortfalls were identified clinics were held to address them. For example, clinics had been held for patients over 65 year of age who had not received flu vaccinations. This meant that the practice was using QOF to help them improve the outcomes of their patients.

Governance/management meetings were held on a regular basis to consider quality, safety and performance within the practice. This included monitoring information from the practice QOF which was analysed and reviewed to enable the practice to make comparisons to national performance and locally agreed targets. Information from clinical audits was reviewed and actions taken to achieve potential improved outcomes for patients.

Staffing

We saw evidence, and the staff we spoke with confirmed that there were processes in place for managing performance and professional development. Records showed that the clinical team were appropriately qualified and supported to access ongoing training and development appropriate to their roles. A detailed appraisal hierarchy exists through team leaders, department heads, managers and partners. Staff told us that they had annual appraisals where training needs were identified, performance reviewed and aims for the coming year set, all of which were documented. Clinical staff also stated that they had clinical supervisions. The practice had a comprehensive induction programme for all new members of staff to follow to enable them to settle into their role. All the staff we spoke with were complementary about the practice and said that they felt supported in their respective roles and felt free to raise any concerns they may have with colleagues and the management team.

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, the palliative care team. Multi-disciplinary meetings were held regularly and included clinicians from the practice, social services and community teams involved in patient care/treatments. This meant that patients received care/treatment that was co-ordinated between the various service providers.

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 timely ongoing preventative care and support from 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 vaccinations and health checks. We saw that some information was provided in languages other than English, for example, Arabic, Polish and Farsi. The practice also had a website that displayed details about health promotion activities such as healthy eating. In addition it explained the signs and symptoms of diabetes. This meant that the practice had used numerous and varied methods of offering their patients' health advice.

Are services caring?

Summary of findings

Overall, patients experienced a caring service. The comments we received were mostly positive. The practice's March 2014 patient survey showed that a majority of patients said that the service was excellent or very good.

Our findings

Respect, dignity, compassion and empathy

The practice had a queue barrier at reception to remind patients to keep a discrete distance from the reception desk when patients were being attended to by reception staff. Additionally piped music was played to reduce the risk of conversation taking place at reception being overheard by other patients or visitors. A room was available to patients who wished to speak to reception staff in a more private environment.

The practice manager explained that they had a confidentiality agreement and every member of staff that sees patients or their details or has access to patient records must sign the agreement. In addition they had a fax policy whereby staff called the intended recipient before and after a fax was sent to ensure safe receipt.

The practice displayed notices advising patients that chaperones were available. There were male and female chaperones available on request. Staff told us that, in accordance with their policy, all patients who required intimate examinations were automatically offered a chaperone. All the consulting rooms we saw had privacy curtains. Some of the comment cards were very complimentary about the services they had received. One patient told us that they had no concerns or worries about the practice maintaining their privacy and treating them with respect.

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.

The practice had patients from different cultural backgrounds. For patients whose first language was not English staff told us that that they used an interpreter service.The touch screen booking in facility was available in four languages other than English.This meant that the practice were better able to maintain patient confidentiality for its group of patients when patients were accessing or receiving a service from the practice.

Are services caring?

Involvement in decisions and consent

Patients told us that they felt involved in the decisions that were made about their care and treatment.They said that clinicians had time to listen, explained things well and that they were able to ask all the questions they wanted to about their care and treatment. One patient commented that staff listened and responded to their questions and where able to discuss options available. Another said the clinicians were supportive and they felt able to talk to them and they explained treatment options. Patients told us they could choose which doctor they wished to see and were able to see them. We saw that the practice had a range of leaflets 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.

The practice had a Patient Participation Group (PPG) who organised and co-ordinated regular meetings and patient surveys.We spoke with two 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.We looked at the most recent patient survey results and saw that the majority of comments were positive and some of the suggestions had already been implemented within the practice, for example, the practice took on additional reception staff to help reduce the telephone answering response times that had been highlighted as an issue. 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.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the practice was responsive to patient's needs. Patients were given the opportunity to make suggestions to improve the practice through the active Patient Participation Group and Virtual Patient Reference Group which the practice had set up to channel suggestions to the management team. In addition patients could raise issues with the practice in various other ways including in person or 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 manager explained that the practice focussed on the Quality Outcomes Framework (QOF) scheme to guide the delivery of their services. A lead clinician was allocated a QOF domain to manage. This ensured that there was a nominated clinician to oversee the outcomes of a particular group(s) of patient. This meant that the practice could better manage, analyse and respond to any issues that were highlighted by the QOF reports.

The premises were Disability Discrimination Act 1995 compliant. For those patients with mobility issues, the practice had a ramp at the main entrance and a lift from the lower ground car park to enable them to more easily access the practice. In addition there was a wash room available that was designed for use by wheelchair users. The practice used interpreters to cater for their non-English speaking patients.

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

There was an independent pharmacy located on the ground floor of the practice.This meant that it was convenient for patients to collect their medication and seek further health and wellbeing advice from a pharmacist.

The practice promoted a confidential contraception and sexual health service for young people in Brighton and Hove. Information was provided, on a poster, advising that patients were not required to register or make an appointment to access these services.This meant that young patients were made aware of and given the opportunity to access these confidential services that were available for them independently of the practice.

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 provided a mechanism though which improvements to patient

Are services responsive to people's needs?

(for example, to feedback?)

services, experiences and care can be highlighted and actions decided. The practice also had a Virtual Patient Reference Group which was comprised of volunteer patients who engaged with the practice remotely.

We spoke with two representatives of the PPG on the day of our inspection.They confirmed that the group met regularly four to six times throughout the year, with the practice. They had action plans in place to work to, for example they reviewed the results of the annual patient surveys and questionnaires, discussed progress against the action plans and agreed ways forward. The PPG have been involved in discussions about telephone answering/ response times. To address the issues raised the practice has employed more reception staff and installed a new telephone system.

The practice and the PPG had worked closely together to engage with the local community, for example, links were established with the local Greek community. The practice was aware that diabetes is prevalent in this population group. GPs from the practice held diabetes awareness sessions with members of the Greek community.

Working with the CCG the practice and the PPG used a social media website which helped them to engage with young Polish patients in particular, the Polish community and the local community.

We were told that patients had requested that the practice is opened on Saturdays and a business case had been sent to the Clinical Commissioning Group (CCG) to request funding for the additional hours required.

Access to the service

We saw that the appointment system was comprehensive and were given a demonstration of how it worked. There was a mix of appointment types, bookable and non-bookable, face to face appointments and telephone triage. Patients could book appointments in a number of ways in person at the practice, by telephone or online. The practice operated extended hours twice a week Tuesdays and Thursdays. We were told that that there was a full cross section of staff available during these times to ensure a full service was available. When the practice was closed patients were guided by messages on the practice website, telephone answer machine and notices in the waiting area to telephone NHS 111 for assistance or 999 in an emergency.There was a poster at the main entrance door, visible from outside, which gave advice on how to access medical help for anyone who arrived while the practice is closed.

One patient we spoke with told us that they used the online booking service, it was easy to use and they were able to get the appointments they wanted. Another patient said that they used the online booking system to make appointments and found it to be flexible and could book appointments to suit their working hours and had pre-booked appointments in advance.

Concerns and complaints

The practice had a complaints policy, and a procedure that was explained in the guidance for staff and the information leaflet for patients. This set out how complaints would be addressed, who by, and the timeframes for responding. The policy and procedure reflected the requirements of the NHS complaints process and included the details of external bodies for complainants to contact if they preferred.

Patients were able to raise their complaint or comment in a number of ways, speak in person, telephone or write to the practice manager, use the comment forms available in the lobby, use the online messaging service or use the feedback form on the practice website.

Staff told us that the practice held regular meetings to discuss the complaints they had received, explore any learning from the events and shared their views and decisions with colleagues.

Representatives of the PPG explained that they had arranged talks for patients that covered a variety of topics that included explaining the best way to make a complaint/comment. They also told us that the practice had been responsive to comments and feedback.

Are services well-led?

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

Summary of findings

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

Our findings

Leadership and culture

We saw that the leadership was well established. The practice was divided into various departments, broadly under clinical and administrative headings each with a head of department with defined roles and responsibilities. There were also team leads and team members. In addition there were lead clinicians who were responsible for various QOF domains. The practice manager explained that the partners had given them the freedom and autonomy to manage the practice. This meant that it was clear who within the partnership practice was responsible and accountable for the services being provided to patients.

Staff we spoke with said that the practice operated a 'no blame' culture and used incidents to learn and improve patient care. Another member of staff told us there was a learning culture at the practice. Staff also commented that their colleagues were approachable and supportive, there was good team work amongst all clinicians and they felt they were always able to go to someone with any issues or concerns.

Administrative staff we spoke told us that the administration team had a voice and were listened to, for example, they made suggestions concerning the duty GP role that were implemented. They also said that they received feedback after the weekly management meetings. This meant that patients were cared for by staff who worked in an environment where they felt supported and able to freely raise any issues in the knowledge that they would be listened to.

The practice manager explained that currently there was no formal succession planning in place, nonetheless future planning was an agenda item for management meetings. We were told that the partnership agreement is currently being revised and updated to ensure that the GPs do not retire together. This means that the practice will be able to manage any changes in the mix of clinical skills and experience for the benefit of their patients and the delivery of all their services. A deputy practice manager had been appointed with a view that following a period of training and mentorship they would take over from the practice

Are services well-led?

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

manager when they moved on. This meant that the practice had taken steps to try to ensure continuity of patient care through various anticipated changes in circumstances, for the benefit of all their patients.

Governance arrangements

The practice had a clinical governance GP lead. The governance arrangements within the practice included the delegation of responsibilities to named clinicians, for example, GP lead for safeguarding, and a nurse lead for infection control. This provided a structure and enabled staff to understand who to approach for support and guidance in specific areas when required.

Staff we spoke with said that they attended learning events, which were initiated by the CCG and available for all practice staff approximately every eight weeks.

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.

Systems to monitor and improve quality and improvement

There were dedicated staff who were responsible for specific domains of the practice QOF data. Staff told us that they held weekly meetings to review and discuss the data to determine how best they can use their resources to provide an effective service that promoted good outcomes for their patients. In addition we were told that patients were contacted where specific QOF shortfalls were identified.

The practice used a detailed appraisal system to monitor staff and assist in improving the quality of the services they provided to patients. Appraisals could, if appropriate, be undertaken or reviewed by team leaders, department heads, managers and the partners. The practice manager told us that annual appraisals are tracked to ensure good oversight of staff performance and action points are followed-up.

Patient experience and involvement

We saw that engagement with patients was managed through the PPG and VPRG. We spoke with representatives of the PPG during the inspection. They told us that management were very responsive to suggestions and supportive of the PPG. We saw examples of where changes had been made or agreed to in response to comments and feedback received from patients, for example the practice has made a commitment to use funding to upgrade some of the clinical rooms.

The PPG gave us an example of how the practice reached out to the local community to engage with members of the Greek community by holding GP led meetings to raise awareness of diabetes and encouraged attendees to seek medical advice if they had any concerns in that regard.

The practice had a whistleblowing policy. We saw that it explained how to raise a whistleblowing concern, what support the practice would provide the whistleblower and where to access independent advice. In addition it gave details of external contacts that could also be approached for guidance but those details referred to organisations that no longer exist and therefore this information need updating. Staff we spoke with were aware of the whistleblowing policy and were confident that if they raised such a concern it would be dealt with correctly.This meant that the practice had a mechanism that staff had confidence in using to raise whistleblowing concerns which provided an additional level of safety to patients.

Staff engagement and involvement

We saw that the various departments held regular management and staff meetings. Staff told us that the minutes from most of the various meetings were distributed to all staff or they were made accessible to them. Team leaders also cascaded information from meetings to their colleagues. Staff told us that specific meetings were held to discuss complaints and significant events and any learning was shared with colleagues.

Learning and improvement

The practice was designated as a training practice where trainee GPs were offered placements to develop their knowledge, skills and clinical competencies towards qualifying as a GP. Trainee Paramedic Practitioners also undertook training at the practice. This was considered important to the practice in keeping knowledge up to date, strengthening and supporting an exchange of learning and innovation amongst all clinicians.

Are services well-led?

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

Identification and management of risk

We saw that systems and processes were in place to manage risks. For example the practice had a detailed business continuity plan. It was comprehensive and included details on how to contact patients in the case of an emergency.

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 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. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service. The practice had policies and procedures to protect older patients.

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

We found the practice to be caring in the support it offered older patients, for example health checks were available to patients aged seventy-five years and over who had not been seen by a GP in the past twelve months.

The practice was well-led and responsive in that it monitored this population group through its analysis of the QOF indicators.

Our findings

Safe

The practice had a safeguarding policy for vulnerable adults/older patients. Staff were able to confidently explain what signs to be aware of that indicated potential abuse and what action to take if they had concerns. This meant that older patients were protected from the likelihood of abuse not being recognised and acted upon.

The practice had a whistleblowing policy. This meant that staff could raise whistleblowing concerns appropriately which may protect patients.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out for clinical staff and the practice manager. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice provided annual flu vaccination clinics for older patients, to provide ongoing protection/prevention from contracting the virus and associated complications/ illness.

Caring

Health checks were available to patients aged seventy-five years and over who had not been seen by a GP in the past twelve months.

Effective

For patients who were diagnosed with dementia some consultations may include family subject to addressing the issues of confidentiality and capacity to consent.

Responsive

The practice was responsive in that it monitored this population group through its analysis of the QOF indicators to identify which patients needed assessments of their health.

Older people

Well-led

The practice was well-led in that it monitored this population group through its analysis of the QOF indicators to identify which patient groups including older patients may need specific services.

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 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. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice had policies and procedures to protect patients with long term conditions.

The practice offered annual flu vaccinations routinely to patients with long term conditions to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered patients with long term conditions, for example regular health clinics were undertaken to monitor their asthma.

The practice was well-led and responsive in that it monitored this population group through its analysis of the QOF indicators.

Our findings

Safe

The practice had a safeguarding policy for children and vulnerable adults. Staff were able to confidently explain what signs to be aware of that indicated potential abuse and what action to take if they had concerns. This meant that patients with long term conditions were protected from the likelihood of abuse not being recognised and acted upon.

The practice had a whistleblowing policy. This meant that staff could raise whistleblowing concerns appropriately which may protect this patient group.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out for clinical staff and the practice manager. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice provided annual flu vaccination clinics for patients with long term conditions, to provide ongoing protection/prevention from contracting the virus and associated complications/illness.

Caring

Annual health checks were undertaken for patients with long term conditions.

Effective

For patients who were diagnosed with dementia some consultations may include family subject to addressing the issues of confidentiality and capacity to consent.

People with long term conditions

Responsive

The practice was responsive in that it monitored this population group through its analysis of the QOF indicators to identify which patients needed recalling for assessment of their treatment and other health needs.

Well-led

The practice was well-led in that it monitored this population group through its analysis of the QOF indicators to identify which patient groups including patients with long-term conditions may need specific services.

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 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. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice had policies and procedures to protect mothers, babies, children and young patients.

The practice offered immunisations to mothers, babies, children and young patients to help protect them against viruses and associated illness.

We found the practice to be caring in the support it offered mothers, babies, children and young patients, for example, they offered checks on new-born babies following home delivery.

The practice was well-led and responsive in that it monitored this population group through its analysis of the QOF indicators.

Our findings

Safe

The practice had a safeguarding policy for children and vulnerable adults. Staff were able to confidently explain what signs to be aware of that indicated potential abuse and what action to take if they had concerns. This meant that mothers, babies, children and young patients were protected from the likelihood of abuse not being recognised and acted upon.

The practice had a whistleblowing policy. This meant that staff could raise whistleblowing concerns appropriately which may protect this patient group.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out for clinical staff and the practice manager. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice provided annual flu vaccination clinics for patients with long term conditions, to provide ongoing protection/prevention from contracting the virus and associated complications/illness.

Caring

The practice offered immunisations to mothers, babies, children and young patients to help protect them against viruses and associated illness.

Effective

There were mechanisms in place to ensure that information received from other service providers was used to improve safety for babies, children and young patients for example, the contact details for Children's Health Visitors was made available to mothers.

Mothers, babies, children and young people

Responsive

The practice was responsive in that it monitored this population group through its analysis of the QOF indicators to identify which patients needed recalling for assessment of their treatment and other health needs.

Well-led

The practice was well-led in that it monitored this population group through its analysis of the QOF indicators to identify which patients from this patient group needed follow up appointments.

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 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. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice had policies and procedures to help protect working age patients.

The practice offered annual flu vaccinations routinely to working age patients who satisfied the requirements to help protect them against the virus and associated illness.

We found the practice to be caring in the support it provided, offering health checks to working age patients who had not been seen by a GP or nurse in the past three years.

The practice was well-led and responsive in that it monitored this population group through its analysis of the QOF indicators.

Our findings

Safe

The practice had a safeguarding policy for children and vulnerable adults. Staff were able to confidently explain what signs to be aware of that indicated potential abuse and what action to take if they had concerns. This meant that working age patients were protected from the likelihood of abuse not being recognised and acted upon.

The practice had a whistleblowing policy. This meant that staff could raise whistleblowing concerns appropriately which may protect this patient group.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out for clinical staff and the practice manager. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice offered annual flu vaccinations routinely to working age patients who satisfied the requirements to help protect them against the virus and associated illness.

Caring

We found the practice to be caring in the support it provided, offering health checks to working age patients who had not been seen by a doctor or nurse in the past three years.

Effective

There were mechanisms in place to ensure that information received from other service providers was made available and used to improve the health and well-being of this patient group. For example, there were numerous leaflets available in the waiting room offering guidance on healthy living and contact details for other health care providers and charities who have an interest in health and well-being.

Working age people (and those recently retired)

Responsive

The practice was responsive in that it monitored this population group through its analysis of the QOF indicators to identify which patients needed recalling for assessment of their treatment and other health needs.

Well-led

The practice was well-led in that it monitored this population group through its analysis of the QOF indicators to identify which patients from this patient group needed follow up appointments.

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 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. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice had policies and procedures to protect patients in vulnerable circumstances who may have poor access to primary care.

The practice offered annual flu vaccinations to patients in vulnerable circumstances who may have poor access to primary care to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered patients in vulnerable circumstances, for example, they ran an initiative where nurses visited housebound patients.

The practice was well-led and responsive in that it monitored this population group through its analysis of the QOF indicators.

Our findings

Safe

The practice had a safeguarding policy for children and vulnerable adults. Staff were able to confidently explain what signs to be aware of that indicated potential abuse and what action to take if they had concerns. This meant that patients in vulnerable circumstances who may have poor access to primary care were protected from the likelihood of abuse not being recognised and acted upon.

The practice had a whistleblowing policy. This meant that staff could raise whistleblowing concerns appropriately which may protect this patient group.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out for clinical staff and the practice manager. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice had policies and procedures to protect patients in vulnerable circumstances who may have poor access to primary care.

Caring

We found the practice to be caring in the support it offered patients in vulnerable circumstances, for example, they ran an initiative where nurses visited housebound patients.

Effective

There were mechanisms in place to ensure that information received from other service providers was made available and used to improve the health and well-being of this patient group, for example, there were

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

numerous leaflets available in the waiting room offering guidance on healthy living and contact details for other health care providers and charities who had an interest in health and well-being.

Responsive

The practice was responsive in that it monitored this population group through its analysis of the QOF indicators to identify which patients needed recalling for assessment of their treatment and other health needs.

Well-led

The practice was well-led in that it monitored this population group through its analysis of the QOF indicators to identify which patients from this patient group needed follow up appointments.

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 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. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice had policies and procedures to protect patients experiencing poor mental health.

The practice offered annual flu vaccinations routinely to patients experiencing poor mental health who satisfied the requirements to help protect them against the virus and associated illness.

We found the practice to be caring in the support it offered, to patients experiencing poor mental health, for example, they offered appointments to patients suffering major depression.

The practice was well-led and responsive in that it monitored this population group through its analysis of the QOF indicators.

Our findings

Safe

The practice had a safeguarding policy for children and vulnerable adults. Staff were able to confidently explain what signs to be aware of that indicated potential abuse and what action to take if they had concerns. This meant that patients experiencing poor mental health were protected from the likelihood of abuse not being recognised and acted upon.

The practice had a whistleblowing policy. This meant that staff could raise whistleblowing concerns appropriately which may protect this patient group.

We looked at some staff files and saw that appropriate pre-employment safety checks had been carried out for clinical staff and the practice manager. However, the practice had not undertaken a risk assessment for non-clinical staff who had contact with patients, for which they do not hold a current security check from the Disclosure and Barring Service.

The practice offered annual flu vaccinations routinely to patients experiencing poor mental health who satisfied the requirements to help protect them against the virus and associated illness.

Caring

We found the practice to be caring in the support it offered to patients experiencing poor mental health, for example, they offered appointments to patients suffering major depression.

Effective

There were mechanisms in place to ensure that information received from other service providers was made available and used to improve the health and well-being of this patient group, for example, there were numerous leaflets available in the waiting room offering guidance on mental health and contact details for other health care providers and charities who had an interest in mental health and well-being.

People experiencing poor mental health

Responsive

The practice was responsive in that it monitored this population group through its analysis of the QOF indicators to identify which patients needed recalling for assessment of their treatment and other health needs.

Well-led

The practice was well-led in that it monitored this population group through its analysis of the QOF indicators to identify which patients from this patient group needed follow up appointments.

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 Family planning services Maternity and midwifery services Surgical procedures 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 had not undertaken risk assessments to identify and manage risks in relation to staff that had contact with patients but had not undergone security checks.**