Binfield Surgery

Quality Report

Binfield Surgery, Terrace Road North, Binfield,
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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	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Binfield Surgery on 1 October 2014. We were also following up on concerns we found regarding protecting patients from abuse and monitoring of the service from January 2014. We visited Binfield Surgery**,** Terrace Road North, Binfield, Bracknell as part of the inspection. The practice is rated as Good. Although many aspects of the practice were good, improvements in safety are required.

Our key findings were as follows:

Patient feedback from surveys, comment cards and verbal feedback was overall positive. The majority of patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. The practice enabled patients to book appointments quickly. Patients with limited mobility were able to access the practice. The practice involved patients in the core strategy and day to day running of the practice. There were concerns regarding the management and dispensing of medicines which could have impacted on patient safety. The practice did not follow all of the requirements related employing and recruitment staff. Not all training required by staff was delivered to ensure that they could provide safe and effective care.

The practice had improved clinical governance arrangements since our last inspection. National guidance and best practice was reflected in the monitoring and delivery of patient care. Improvements to safeguarding procedures meant that staff were aware of their responsibilities in protecting patients from abuse.

There were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- make changes to the processes for obtaining, storing and dispensing medicines.
- ensure that all information required relating to staff checks, such as references, Disclosure and Barring

Summary of findings

Service (DBS) as per the DBS risk assessment (including a system to update and renew Criminal Record Bureau checks) and identification documents, are in place and available in staff records
- must ensure hygiene and infection control training is provided to all relevant staff.
- provide Mental Capacity Act 2005 awareness to all relevant staff.

We have issued three compliance actions for the regulations relating to Recruitment, Supporting Workers and Medicines management.

In addition the provider should:

- introduce a comprehensive infection control audit.
- ensure that contingency plans for medical emergencies are in place and clearly communicated to the team.
- review their appointments process.
- consider the planning and delivery of care provided to patients with learning disabilities and those with other complex needs.

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?

Inadequate

The practice is rated as inadequate for safety. Staff were not always communicated with effectively regarding risks to patient safety, such as faulty emergency equipment. Medicines were not stored, managed or dispensed in line with national guidance. Dispensing staff did not receive appropriate training. Staff information regarding recruitment and background checks was not completed in line with relevant guidance. Health checks required for staff to treat patients were not undertaken on some staff. There were systems in place to monitor, respond and learn from identified risks. Clinical risks and incidents were identified and acted on appropriately. GPs and nurses were supported to understand their role in protecting patients from abuse.

Are services effective?

Requires improvement

The practice is rated as requires improvement for effective. Data showed patient outcomes were at or above average for the locality. National guidance was reflected in patient care and treatment. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff received some training appropriate to their roles but further training needs were identified, including awareness of the Mental Capacity Act 2005. The practice appraised staff. Multidisciplinary working between the practice and external services was undertaken to deliver continuity in patient care. Some patients had a designated GP but some patients with complex needs did not.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice as good in several aspects of care. The majority of patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Requires improvement

The practice is rated as require improvement for responsive. The practice reviewed and understood the needs of their local population. The practice identified and took action to make improvements. Patients reported that they could access the practice when they needed and access compared better to national and local CCG data. Some patient feedback reported concerns about consistency in care. Some staff were concerned that appointments

Summary of findings

were sometimes added to the usual daily appointment list due to patients who needed to see a nurse or GP. Patients with learning disabilities did not have a named GP and needed to attend another practice to receive annual health checks as the practice did not provide these checks. There were no named GPs for patients other than those over 75, but the majority of patients reported that their care was good. The practice was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded appropriately and in a timely way to issues raised. There was evidence that learning from complaints was shared with staff.

Are services well-led?

Requires improvement 

The practice is rated as requires improvement for well-led. The monitoring of medicines and staff training was not sufficient. The practice had not managed where risks were identified. This included where staff background checks were required following risk assessments. The practice had a clear vision and strategy to deliver quality care and treatment. Staff reported an open culture and told us they could communicate with senior staff. They felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. However, we found some concerns regarding communication amongst staff and examples where this could impact on safety. There were systems in place to monitor and improve quality and identify risks. There were systems to manage the safety and maintenance of the premises and to review the quality of patient care. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG) which was involved in the core decision making processes of the practice. Patient engagement was central to the operation of the practice.

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 provided quality care to older patients. Health checks and promotion were offered to this group of patients. Data showed the practice cared well for older patients. There were safeguards in place to identify adults in vulnerable circumstances. The practice worked well with external professionals in delivering care to older patients, including end of life care. The practice had implemented care plans for patients at risk of being admitted to hospital as part of an optional enhanced services scheme. This included older patients. Patients over 75 years old had a named GP to provide continuity in care.

People with long term conditions

Good

The practice managed the care and treatment for patients with long term conditions in line with best practice and national guidance. Health promotion and health checks were offered in line with national guidelines for specific conditions such as diabetes and asthma. Although the practice did not provide named GPs for patients with chronic medical conditions, patients felt well cared for and said they could access the practice. The practice had implemented care plans for patients at risk of being admitted to hospital as part of an optional enhanced services scheme. This included patients with long term conditions. Longer appointments were available for patients if required, such as those with long term conditions. Monitoring of medicines dispensed by the practice was not undertaken in way that fully protected patients from the risk of inappropriate use of medicines. This was a potential risk to patients on long term prescriptions due to health problems.

Families, children and young people

Good

The practice had a high proportion of young children and babies. Staff worked well with the midwife to provide prenatal and postnatal care. Some patients reported that getting postnatal health checks with a GP was difficult. The practice achievement for baby and child immunisations matched the regional average. Information relevant to young patients was displayed and health checks and advice on sexual health were provided in line with national guidance.

Working age people (including those recently retired and students)

Good

The practice population had a higher than average number of patients who were employed. The practice provided appointments on the same day, although appointments could only be booked if

Summary of findings

patients called before 10am. The practice operated extended opening hours on Mondays and Thursdays with either one GP or a nurse or two GPs. There was no online booking system at the time of our inspection. Patients generally reported that they could access appointments. The practice worked with a local college to ensure students were registered and able to attend Binfield Surgery when they needed. Patients over 45 could arrange to have a health check with a healthcare assistant if they wanted. A cervical screening service was available. Telephone consultations were available for patients, which benefitted those who worked.

People whose circumstances may make them vulnerable

Requires improvement

The practice provided information for GPs and nurses to consider for patients who were vulnerable. Staff received safeguarding training, and GPs and nurses had access to safeguarding policies. GPs had training in the Mental Capacity Act (MCA) 2005 but some nurses did not have an adequate understanding or appropriate guidance available in relation to the Act. This could affect the rights of patients who may lack capacity to make decisions about their care or treatment. Learning disability patients were not offered annual health checks at the practice, they were referred to a different practice in Bracknell. Patients who may be vulnerable due to personal circumstances or health concerns did not have a named GP at the practice.

People experiencing poor mental health (including people with dementia)

Requires improvement

Monitoring of medicines dispensed by the practice was not undertaken in way that fully protected patients from the risk of inappropriate use of medicines. This was a potential risk to patients on long term prescriptions such those who suffer from poor mental health. There was not an appropriate awareness or protocol provided on the Mental Capacity Act 2005 for nurses. The practice hosted support services for patients with poor mental health. There was signposting and information available to patients. The practice referred patients who needed mental health services. Some support services were provided at the practice, such as Talking Therapies. Community mental health services did not attend multi-disciplinary team meetings with the staff from the practice. Patients suffering poor mental health were offered annual health checks as recommended by national guidelines. There were no individual GP lists for patients suffering from poor mental health. Quality Outcomes Framework (QOF) data showed the practice achieved a high proportion of health checks for patients with schizophrenia. There was no signposting for external services which could be useful for patients with dementia listed on the website.

Summary of findings

What people who use the service say

We looked at patient feedback from the national GP survey from 2014 which had approximately 150 responses and the practice survey from 2013 which received 208 responses. The surveys reported that access to the practice was very good and patients could see a GP quickly. Eighty nine % of patients were able to get an appointment or speak to a GP or nurse last time they tried. There was very positive feedback about the way staff spoke with and supported patients. The majority of feedback was positive. There was some feedback which was below the national average for how well clinicians, particularly nurses, supported patients in making decisions. Patient feedback on how often they saw a GP of their choice was below national average. Most patients said this did not affect their care.

We spoke with 14 patients during the inspection and collected 21 completed comment cards which had been left in the reception area for patients to fill in before we visited. The vast majority of feedback was positive. Patients told us their care was very good and they could access the practice easily. Some patients told us it was difficult to get through on the phone because patients had to book an appointment before 10am in order to see a GP. Patients were complimentary about the repeat prescription service.

Areas for improvement

Action the service MUST take to improve

- make changes to the processes for obtaining, storing and dispensing medicines.
- ensure that all information required relating to staff checks, such as references, Disclosure and Barring Serivce (DBS) as per the DBS risk assessment (including a system to update and renew Criminal Record Bureau checks) and identification documents, are in place and available in staff records
- must ensure hygiene and infection control training is provided to all relevant staff.
- provide Mental Capacity Act 2005 awareness to all relevant staff.

We have issued three compliance actions for the regulations relating to Recruitment, Supporting workers and Medicines management.

Action the service SHOULD take to improve

- introduce a comprehensive infection control audit.
- ensure that contingency plans for medical emergencies are in place and clearly communicated to the team.
- review their appointments process.
- consider the planning and delivery of care provided to patients with learning disabilities and those with other complex needs.

Binfield Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a former practice nurse with management experience, a pharmacy inspector and expert by experience. Experts by Experience are people who have experience of primary medical services as patients themselves.

Background to Binfield Surgery

Binfield surgery is located on one site. The premises has treatment and consultation rooms on the ground floor with wheelchair access at reception. There are three practice partners and a total of five GPs working at the practice, as well as locums. Both male and female GPs work at the practice. The nursing team consists of three practice nurses and one healthcare assistant. Binfield Surgery dispenses medicines to patients.

The practice has a Personal Medical Services (PMS) contract. PMS contracts are locally arranged and are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the British Medical Association.

The practice was last inspected in January 2014 and we found concerns regarding the regulations for protecting patients from abuse and assessing and monitoring the quality of service provision. We issued compliance actions for these regulations and asked the provider to send us an action plan of how they would achieve compliance. During this inspection we followed up on our concerns as well as undertaking a comprehensive inspection. The practice had met compliance with the standards where we found concerns in January 2014.

We visited Binfield Surgery**,** Terrace Road North, Binfield, Bracknell, RG42 5JG as part of this inspection.

This practice does not provide Out of Hours coverage to patients, they have a contract with a local provider and information is displayed in the practice.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had been inspected before and we checked to ensure concerns we identified had been addressed.

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Bracknell Forest Healthwatch, NHS England and Public Health England. We visited the Binfield Surgery on 1 October 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff, patients and representatives of the patient participation group (PPG). We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We

Detailed findings

looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

The practice had not raised any safeguarding alerts within the last year. We looked at safety incidents recorded and saw they were investigated and actions put in place to reduce the risk of them reoccurring. The practice had identified two dispensing errors which were discussed at a practice meeting and the storage of these items was changed to minimise the risk of it happening again. Staff were aware of where they could report patient safety concerns within the practice and externally if they needed to.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw records of significant events that had occurred during 2014. Team meeting minutes showed significant events were discussed to identify concerns and share learning with the staff. The significant events log was discussed frequently at staff meetings to identify trends. Complaints were discussed at team meetings and some were recorded as significant events. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. All staff were aware of the system for raising issues to be considered at the meetings and told us they were encouraged to do so.

Reliable safety systems and processes including safeguarding

All staff had received training on safeguarding. GPs and nurses had undertaken the appropriate level of safeguarding children training within the last year. Safeguarding adults and children policies were available on staff computers in treatment and consultation rooms. Most staff were confident in identifying categories and potential identifiers of abuse. Staff told us they would discuss safeguarding concerns with GPs. Staff knew of their responsibilities to report concerns and contact the relevant agencies in and out of hours. Reception staff had received level one safeguarding children training according the practice training matrix.

Vulnerable patients, such as those with a learning disability, older patients who are frail or have dementia or children on the 'at risk' register, were flagged on the practice's computer system to nurses and GPs. The practice worked with external organisations through multi-disciplinary meetings such as the local social care team to share information about vulnerable children and adults.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including the healthcare assistants. Only GPs and nurses performed chaperone roles.

Medicines Management

The practice dispensed medicines for patients. Patient group directions (documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions) were in place for use with vaccines. We saw evidence the practice reported to the yellow card scheme (a means of sharing information where there are adverse reactions to medicines) where appropriate.

There were no standard operating procedures (SOP) for dispensing in operation. We found medicines were stored in unsecured locations in the practice. Only staff had official access to these areas. However, we observed a door to one location was unlocked and there was no monitoring of which staff were allowed access to the medicines. The lack of security meant patients or visitors could have entered the room. There was no stock list in operation therefore the practice was not monitoring the quantities of medicines stored. Only one stock check was done on an annual basis. During dispensing, packets of medicines were being separated and not labelled with a batch number or date of expiry. Medicines could not be monitored or accounted for properly. Patients were not always provided with patient information leaflets (PIL) which is required by national guidance.

The lock on a medicines' fridge had broken within the week before the inspection. The fridge was stored in a corridor. Medicines were not stored securely posing a risk of inappropriate use. We saw medicines were overstocked in the fridge meaning the medicines may not be kept at an appropriate temperature. There was an alarmed thermometer on the fridge to inform staff if the temperature had not been within the required temperatures required to store medicines properly. Records of the fridge temperatures were kept to monitor that the fridge was functioning properly.

Are services safe?

The member of staff responsible for dispensing medicines had no formal qualification to do so and the practice provided no training for them. The practice did not ensure that the staff member responsible for dispensing medicines was appropriately trained to perform the role safely.

Cleanliness & Infection Control

The practice had a lead for infection control. There was a policy and protocols for staff to follow. For example, action to take in the event of a sharps injury was listed on clinical treatment room walls. The practice undertook an audit on infection control in July 2014. This was not undertaken by the infection control lead, but they were aware of changes made in the practice due to the audit results. This included non-touch hand soap dispensers. The audit tool was created by the practice and did not include the breadth of checks that nationally recognised tools include. We asked a nurse what training staff had in infection control and they told us they received training organised by the clinical commissioning group (CCG) but were not sure when this was. Proof of staff hepatitis B immunisation records were not available on all the staff files we looked at.

We saw the treatment rooms were clean and hygienic. Medical instruments such as the spirometer and the ear syringing equipment were cleaned regularly and there were recorded checks to ensure the equipment was clean. There were colour coded sharps bins which were not overfull. The hygiene and infection control lead told us they were responsible for monitoring the clinical waste and sharps bins. The practice manager told us regular cleaning checks were undertaken on the consultation rooms and clinical treatment rooms. Consultation rooms were carpeted and the infection control lead and manager told us they were steam cleaned yearly. We saw correspondence from the contractor used to clean the carpets, confirming steam cleaning had taken place.

Equipment

Electrical appliances were tested to ensure they were safe. Fire extinguishers were maintained and checked by an external company every year. We saw servicing records for medical equipment were up to date. Disposable medical instruments were stored in clinical treatment rooms in hygienic containers ready for use. We found medical equipment and supplies were within their date of expiry.

Staffing & Recruitment

We saw staff were provided with an induction planner when they commenced employment. This included policies and procedures about working at the practice. Locums were provided with a locum pack. Staff files contained some information required for the recruitment of staff who provide care to patients. However, some GPs and nurses registration details were not available to evidence that the practice checked their registration was current with the appropriate professional bodies. Disclosure and Barring Service (DBS) guidance recommends that practices consider which staff require DBS checks based on a risk assessment. The practice had undertaken a risk assessment on which staff members required DBS checks. This included three nurses who had not received DBS checks since working at the practice. However the nurses' DBS checks had not been completed. The practice manager told us they had requested the forms for the two nurses to complete the DBS checks approximately a month before the inspection but they were still due to be completed. There were DBS checks for all other staff identified as requiring them in the risk assessment.

Some staff files did not contain copies of identification documents or references where staff had worked in health or social care to ensure their previous conduct had been checked.

The practice employed a variety of administration and reception staff. The practice was able to increase the numbers of staff on the phone during busy times to help patients get through to the practice. There was a dispensing and prescribing clerk at the practice to manage the dispensing of medicines. The GP partners performed roles outside of the practice and used regular locums to cover for them. There were systems in place to reduce the risk of inconsistency in patients' care. The practice also used agency locums on occasions when they were short staffed. However, some patients reported it was difficult to see the same GP regarding the same concerns they had. The national patient survey found that 49% of patients with a preferred GP were not able to see them when they wanted. Although patients found it difficult to see their choice of GP, the national survey and patients we spoke with reported they could see a GP when they needed to.

Monitoring Safety & Responding to Risk

Some monitoring and assessing of risks took place. For example, we saw a fire risk assessment and an asbestos assessment for the premises. There was a control of

Are services safe?

substances hazardous to health (COSHH) risk assessment available for the storage of chemicals in the practice. We saw portable appliances were tested in line with Health and Safety Executive guidance to ensure they were safe.

The Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service, showed the practice monitored the health and wellbeing of patients who experience poor mental health. This included regular medicine checks and physical health checks.

Arrangements to deal with emergencies and major incidents

The practice had a business continuity plan for ensuring there was a process for dealing with foreseeable emergencies. This was located in the practice manager's office. There were emergency medical equipment and medicines available. However, the practice manager told us the defibrillator was not working for several days. Some staff were not aware the defibrillator was not working. There was a risk that staff would not be able to respond appropriately in a medical emergency if they were unaware the defibrillator was not working. The manager told us they would ensure all staff were informed. The practice did not store a medicine which is recommended for practices that fit coils or have minor surgery clinics.

The practice had alarm buttons to alert staff in the event of emergencies. Following an incident where the alarm was used by a staff member, the practice decided to move the button as a review of the incident revealed that the button was not easily accessible in its original location. The practice reviewed and took action to improve its responsiveness to emergencies and incidents.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All the GP and nurses we interviewed were able to describe and demonstrate how they access both guidelines from the National Institute for Health and Care Excellence (NICE) and other relevant guidance. GPs and nurses demonstrated how they ensured they followed national clinical guidelines. We saw patients' treatment records for specific conditions reflected best practice in treating those conditions. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed.

Patients had their needs assessed and care planned in accordance with best practice. We saw patient care templates were available to staff which reflected national guidance. This helped GPs and nurses to provide consistent care which reflected national guidelines. The practice had implemented care plans for patients at risk of being admitted to hospital as part of an optional enhanced services scheme. This included older patients or patients with long term conditions who may be at greater risk of acute illness. In order to complete the care planning the practice had employed a nurse.

The practice referred patients appropriately to secondary and other community care services. The practice used 'Choose and Book' for referring patients to secondary care services. All referrals were reviewed once a week by the practice to ensure that they were appropriate and patients would get the referral they needed. Referrals would not be sent away to the relevant service until the practice had assessed the referral. This may be up to a week after the initial consultation where the referral was made. National data showed the practice was in line with national standards on referral rates for all medical conditions. We saw evidence from statistics that appropriate use of two week wait referrals was in place.

The practice had palliative care registers which were discussed with external services to ensure continuity of patient care. The practice had a learning disability register which was kept up to date by checking it with the local social care teams. However, GPs told us the practice did not offer patients with a learning disability an annual review of their care. A GP partner told us that patients with a learning disability or their representatives who wanted a comprehensive health check would need to request this and it would be organised with another practice.

We looked at four patient records for either a discharge or clinic letter with actions for medicines. All were completed in a timely manner. Repeat prescriptions were usually processed well within the 48 hours according to staff but there was no audit data to verify this. The practice manager told us there had been no complaints regarding repeat prescriptions in recent years.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF). This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The practice achieved 97% on their QOF score compared to a national average of 96%. The practice reported low exceptions on their QOF submissions (patients may be exempted from the QOF score if they fail to attend for health checks after repeated reminders or cannot receive certain medicines due to medical complications). The practice achieved highly on specific areas including health checks for patients with schizophrenia. The practice had a low A&E attendance among its patient population.

The practice showed us the clinical audits that had been undertaken in the last year. We noted these were discussed at clinical team meetings. These were incomplete audits where the second cycle of audit was yet to be undertaken and reflected on. GPs told us the audits would be repeated where necessary to identify if improvements to patient care had been made as a result of the audits. We saw audits on cancer, C-Difficile, the use of a specific medicine and diabetes were undertaken in response to national guidance or specific concerns with the health needs of the practice population. The diabetes audit from 2013 was undertaken to identify whether diabetes diagnosis could be improved. The audits led to changes in practice or learning outcomes which were shared with staff. Nursing staff told us they were involved in relevant audits. The diabetes audit noted that it was discussed with a diabetes nurse. Staff spoke positively about the culture in the practice around audit and quality improvement. Patients

Are services effective?

(for example, treatment is effective)

with long term conditions received care and treatment which reflected national guidance. This included regular health checks to ensure patients with health conditions were assessed regularly. The regularity of these reviews reflected intervals recommended by NICE.

Effective staffing

The practice had staff folders to assist the manager and staff in monitoring their training including training delivered by the local clinical commissioning group. Staff received external training specific to their role such as diabetes and wound care for nurses. The practice used a recognised tool for providing online training. This document showed all GPs and nurses had undertaken child and vulnerable adults safeguarding training. Some GPs and nurses were not listed as having hygiene and infection control training. Staff were not certain whether they received any training in the Mental Capacity Act (MCA) 2005. There were no certificates to suggest MCA 2005 training was provided.

All staff received appraisals from the practice manager. We saw records of appraisals included training planners for staff. Staff said they found the appraisal process valuable, but would prefer to have clinical input on their next appraisal.

Working with colleagues and other services

The practice worked well with other services. We saw minutes from monthly multi-disciplinary team meetings. The meetings included district nurses and other community care workers. Patients with cancer and those on the palliative care lists were discussed to manage their care and share information. Patients who had recently passed away were discussed to identify any learning and review whether their wishes had been respected. The practice shared antenatal and postnatal care with a midwife who held clinics on site. The midwife provided two antenatal checks ups during pregnancy with expectant mothers.

Information Sharing

The practice had multi-disciplinary team meetings to share information and plan patients' care with external services such as district nurses. Local mental healthcare professionals such as community psychiatric nurses and social care teams did not attend these meetings. This meant some important information about patients may not have been passed onto the practice. The choose and book system for referrals used by the practice enabled information to be shared quickly with other services who patients were being referred to. Staff told us they communicated frequently with care homes in order to plan patients' care and respond to their needs.

Consent to care and treatment

GPs we spoke with had an understanding of the Mental Capacity Act 2005 (MCA). They knew when it may be required to assess someone's capacity to make a decision and how a decision can be made in a patient's best interests. Some nurses did not have an adequate understanding or appropriate guidance available in relation to the Act. The practice MCA policy did not contain detailed information on how to assess the capacity of a patient. GPs demonstrated a clear understanding of the Gillick competencies (guidance on gaining consent from patients under 16).

We saw the practice had consent forms for patients to consent to specific procedures in the practice including minor surgery.

Health Promotion & Prevention

There was information on various health conditions and self-care available in the reception area of the practice. The practice website contained information on health advice and other services which could assist patients. The website also provided information on self-care. The practice offered new patients a health check with a healthcare assistant or with a GP if a patient was on specific medicines when they joined the practice. Patients over 45 could arrange to have a health check with a healthcare assistant if they wanted. A cervical screening service was available. The practice offered smoking cessation advice for smokers who wanted to stop. The practice QOF data from 2013 indicated that the practice was slightly below national average on recording the smoking status of patients.

A travel consultation service was available. This included a full risk assessment based on the area of travel and used the 'Fit for travel' website. Vaccinations were given where appropriate or patients were referred on to private travel clinics for further information and support if needed.

Are services effective?

(for example, treatment is effective)

There was information on external services on sexual health. Young patients are at higher risk of some sexually transmitted infections, particularly Chlamydia. Patients could request testing for Chlamydia and this was advertised on the patient website.

The practice provided information on mental health support services on its website and external support services such as counselling.

The practice was in the process of implementing care planning for patients who were at risk of developing diabetes. This was aimed at reducing the risk of developing the disease and helping patients manage their lifestyle in order to do so. The practice offered child immunisation programmes for all children. The uptake among children under 12 months was 86 %. This was slightly below the clinical commissioning group (CCG) average. For children up to 24 months the uptake of vaccinations was above the CCG average.

The practice offered patients who were eligible, a yearly flu vaccination. This included older patients, those with a long term medical condition, pregnant women, babies and young children. The practice offered flu vaccinations when staff had the opportunity at appointments or by contacting patients via text, phone or email. The uptake among patients who qualified for the flu vaccination under 65 was higher than the national average. For patients older than 65 the practice achieved the national average for uptake of the vaccination. Patients with long term medical conditions were offered yearly health reviews. Diabetics were offered six monthly reviews.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The 2014 patient survey for this practice received approximately 150 patient responses. Eighty two per cent of patients reported that GPs were good at listening and had enough time to listen to them. Seventy eight per cent of patients reported that nurses were good at giving advice and 77 % reported nurses were good at listening. Seventy eight per cent of respondents said that nurses were good at spending enough time with them and 77 % said nurses listened well. Ninety one per cent of patients said receptionists were helpful. The practice survey from 2013 found over 80 % of patients were satisfied with how well nurses and GPs understood patients' individual needs.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 21 completed cards and the majority were positive about the care and treatment experienced. Patients said they felt the practice offered very good services and staff were considerate, helpful and caring. They said staff treated them with dignity and respect. Most feedback was positive. Some patients told us making an appointment was difficult during the morning. Some patients were concerned about not being able to see the same GP at different appointments. Patients were mostly complimentary about their experiences with reception staff.

Staff took steps to protect patients' privacy and dignity. Curtains were provided in treatment and consultation rooms so that patients' privacy and dignity was maintained during examinations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow basic precautions when discussing patients' treatments in order that confidential information was kept private. Receptionists closed a screen on the reception desk when speaking to patients on the phone. This was in response to patient feedback. The practice manager told us patients were offered a room to speak with staff if they needed to discuss any sensitive information.

Care planning and involvement in decisions about care and treatment

Sixty eight per cent of patients said GPs were good at involving them in decisions about their care in the national GP survey. Only 48 % of patients reported the same about nurses. The practice manager and a partner told us they were aware nurses time was pressurised due to the amount of patients wanting to see them and other tasks they carried out. The practice's own survey from 2013 found 80 % of patients were satisfied with the explanation of their treatment plans. Patients we spoke to on the day of our inspection told us they felt involved in decisions about their care and treatment. They also told us they felt listened to and supported by staff.

Patient/carer support to cope emotionally with care and treatment

A practice partner and the manager told us that translation services were available for patients who did not have English as a first language. They said it was rare that this service was required.

Patients told us that they felt well supported by reception staff. We saw older patients were provided with support by receptionists. For example, a receptionist came into the reception area to speak with an elderly patient to explain how long the wait for the appointment would be.

There was a carer's board displayed in the reception area of the practice. There was no system to identify if a patient was a carer when they called to make an appointment. This did not enable receptionists to consider carers' potential needs when calling the practice.

The practice discussed patients who had died, in multi-disciplinary team meetings to identify and review whether their care was appropriate and whether their wishes were respected. One patient told us their relative had passed away and the practice had supported the family during what was difficult time for them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Staff understood the needs of the practice population. GPs we spoke with were aware that there were high numbers of young children and young families. The practice worked well with the midwife who provided appointments at the practice. The practice provided postnatal clinics. Some patients told us it was difficult for patients to get a postnatal check up with a GP.

Patient feedback from surveys and feedback during our inspection indicated that patients found it hard to see the same GP at each appointment they attended. Most patients told us this was not a problem. Some patients reported through surveys and those we spoke with that this affected their continuity of care. GPs had their own patient lists for patients over 75 years of age. The practice did age searches regularly on their patient population to allocate any patients over 75 a GP. There were no other patient lists for GPs. For example, there were no designated GPs for patients with learning disabilities or mental health problems. Patients with learning disabilities needed to attend another practice to receive annual health checks as the practice did not provide these checks. All patients needing to be seen urgently were offered same-day appointments. Feedback from the national patient survey suggested patients were seen quickly at the practice when they needed an appointment.

The practice offered home visits to patients who required them if requested before 10am. This provided older patients, mothers with young children, carers or patients in vulnerable circumstances an opportunity to see a GP when they may have difficulty attending the practice. We did not speak to any patients who used this service.

Longer appointments were available for patients if required, such as those with long term conditions. Telephone consultations enabled patients who may not need to see a GP the ability to speak with one over the phone. This was a benefit to patients who worked full time or could not attend the practice due to limited mobility.

The practice advertised external services such as mental health support services in the waiting area. Support groups and external services were advertised on the website, such as new parent groups. There was no information on the website about local mental health, counselling or drug and alcohol services for patients. The practice hosted 'Talking Therapies' provided by a local mental health support service provider.

The practice had patient registers for learning disability and palliative care. There were regular internal as well as multidisciplinary meetings to discuss patients' needs. The practice worked collaboratively with other care providers such as a local care home and district nurses.

There was an online repeat prescription service for patients. This enabled patients who worked full time to access their prescriptions easily. Patients could also drop in repeat prescription forms to the practice to get their medicines. Patients told us the repeat prescription service worked well at the practice. The practice referred certain prescriptions to pharmacies that delivered for patients who found it difficult to collect their prescriptions.

Tackling inequity and promoting equality

We saw staff received training in equality and diversity. The practice manager and partners were aware of patients who may be vulnerable or have limited access to GP practices. They informed us the practice catchment area included a small traveller community but they were mainly residential and were offered the same services as the general population. The practice confirmed they would offer immediate healthcare to any non-residential member of the traveller community, homeless or vulnerable patients or new migrants who were not registered at a practice. The practice manager informed us staff visited a local higher educational college to make students aware of their services and sign them up to the practice. Staff from the college were represented on the patient participation group.

Access to the service

Binfield Surgery's appointment system enabled patients to see a GP or nurse the same day if they phoned the practice before 10am. There was also a telephone consultation system available for patients. They could request a call back from a GP or nurse. Seventy two per cent of patients were satisfied with the practice's opening hours in the 2014 GP national survey and 89 % said they were able to get an appointment or speak with a GP or nurse when they needed to. Ninety four per cent said appointments were at convenient times. Most patients we spoke with told us they could see a GP when they needed. Some patients told us that getting through on the phones in the morning could

Are services responsive to people's needs?

(for example, to feedback?)

be difficult because the lines were very busy. Reception and nursing staff told us the nurses' appointments could be difficult to find for patients. On the day of our inspection staff told us there were 15 patients who required appointments with a nurse and said this was a common problem. A practice partner and the manager explained these appointments were not urgent but there was an issue with patients wanting an appointment the same day with a nurse and the practice trying to accommodate them all.

The practice had a ramp for patients using wheelchairs to access the practice. The front door and corridors were wide and all consultation and treatment rooms were on the ground floor allowing easy access for wheelchair users. We saw staff supported patients with limited mobility to get to treatment rooms. Staff promoted patients' independence in the way they supported them.

The practice had the medical equipment it required to provide the services it offered. There was a baby weighing scales for use in the corridor of the practice. Clinical treatment rooms had the equipment required for minor surgery and other procedures which took place.

The practice operated extended opening hours on Mondays and Thursdays with either one GP or a nurse or two GPs. This benefitted patients who worked full time or those with children who needed to attend out of school and working hours. There was an online appointment booking system available for patients. This could assist patients who worked full time considering the difficulty some patients reported in booking appointments during the morning.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. The system for raising complaints was advertised on the practice website and in the reception area. There was a designated person who was responsible for dealing with complaints from patients. We saw complaints were acknowledged and responded to. Some complaints triggered the practice's significant event process. All were discussed in staff meetings to identify any learning outcomes and share these with staff. We saw from meeting minutes that complaints were discussed periodically to identify long term concerns or trends.

Are services well-led?

(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 statement of purpose which had key principles including a delivery of best practice in patient care and patient involvement in the running of the practice. Clinical leadership and the integration of the practice's patient participation group (PPG) reflected this. The practice partners were aware of the challenges that would require action in the future regarding the patient population and the needs of that population. The partners told us they projected a significant growth of the patient population due to large housing developments within their catchment area. They all had a shared understanding of the challenges this would pose to the practice in its current building and with current capacity.

Governance Arrangements

The practice held regular clinical and administration staff meetings. The practice partners and manager told us communication was difficult due to staff having external roles and employing part time staff. The practice manager explained they tried to hold ad-hoc meetings with administration staff to ensure they communicated well with all staff. However, we found an instance where a problem with emergency medical equipment had not been communicated with staff. This posed a potential risk to patients. Nurses felt valued by the practice and held their own meetings when they needed to share specific guidance related to their roles. Nurses also said they would benefit from appraisals led by a GP or another nurse as their most recent appraisals were led by the practice manager. Away days were held once a year for all staff to attend and PPG members were invited to attend. PPG members we spoke with were very complimentary about the involvement they had in decisions about the running of the practice. Policies were stored in a central location in the manager's office for staff to access. Safeguarding and the Mental Capacity Act 2005 policies were stored on GPs and nurses' computers. Some administration staff did not know where to access these policies on their computers, although the practice stored the documents on a shared drive.

The practice did not monitor the storage and dispensing of medicines properly. There was a risk that management of medicines was ineffective and unsafe. The system to identify and deliver training was not sufficient to ensure all staff had an appropriate awareness related to their roles. Risk assessments on staffing were not acted on to ensure appropriate checks were undertaken. The practice was not assessing and managing identified risks.

Leadership, openness and transparency

Staff told us they felt there was an open culture at the practice. Staff were clear on their responsibilities and roles within the staff teams. There were delegated responsibilities within the management team and among the partners. Staff and members of the patient participation group (PPG) told us they felt the leadership at the practice were approachable and they felt engaged in the day to day running of the practice. One partner attended PPG meetings to support the work of the PPG and ensure the leadership were fully engaged in patient feedback. GP partners told us they supported the work of the PPG and were very pleased with how it functioned.

Practice seeks and acts on feedback from users, public and staff

We met representatives from the PPG. There was a formal PPG who met regularly and this group had a core membership who met regularly. Their meetings were attended by a practice partner and the practice manager. There was also a virtual PPG of approximately 30 members who the PPG made contact with regularly to involve in decisions about the running of the practice. The practice had a reference group of over 4,000 patients who they were able to contact via email. The PPG sent newsletters to this reference group at least monthly to communicate health promotions and information about the practice. The PPG was also responsible for compiling the practice survey and analysing the results. The PPG members told us that the survey action plan from 2013 was created by the PPG. The PPG members we spoke with were complimentary about the way the practice staff involved them in the running of the practice. They told us they had attended a recent patient safety programme with staff from the practice and were involved in implementing changes within the practice to improve patient safety.

Staff told us they felt involved in the running of the practice. The practice had a whistle blowing policy which was available to all staff. GPs and nurses told us they were encouraged to provide clinical leadership and share learning among the staff group at the practice.

Are services well-led?

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff appraisals included a personal development plans. 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 systems to learn from incidents which potentially impacted on the safety and effectiveness of patient care and the welfare of staff. Clinical team meetings were used to disseminate learning from significant events and clinical audits. Staff told us changes to protocols and policies were made as a result of learning outcomes from significant events, national guidance and audits.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Medicines Management** **There were not appropriate arrangements in place for obtaining, recording, handling, using, keeping safe and dispensing of medicines.** **Regulation 13.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Regulation 21 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements Relating to Workers.** **The provider did not take reasonable steps to ensure that employees were of good character, were physically and mentally fit to perform their roles, that staff were registered with their professional bodies and that information required under schedule 3 was available. Regulation 21 (a)(i)(iii)(b)(c)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting Workers.**

This section is primarily information for the provider

Compliance actions

The provider did not ensure that staff were appropriately supported by receiving training to enable them to undertake their responsibilities safely and to an appropriate standard. Regulations 23 (1)(a)