Bincote Surgery

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

Bincote Surgery is located in the London Borough of Enfield, North London. The practice provides primary medical services to approximately 5,800 patients and is situated in a large, converted, semi-detached house. The practice is registered to provide diagnostic and screening procedures, family planning, surgical procedures and treatment of disease and disorder or injury.

We carried out an announced inspection on 29 May and 2 June 2014. During our inspection we spoke with GPs, the practice nurse, practice manager and reception staff. We also spoke with patients (including patient participation group (PPG) members) and reviewed policies and procedures documentation. We reviewed completed patient comment cards which had been made available to patients in the two weeks prior to our inspection.

Patients spoke positively about how they were treated by clinical and administrative staff. They told us that GPs were compassionate and that the practice listened to and acted on patient concerns. Comment card feedback emphasised the high standard of care that patients felt they received. However, some patients told us they felt that space in the practice was limited.

The practice had systems in place to report and learn from incidents and protect patients from the risk of infection. Staff had received training in how to respond to emergencies and training in child protection and safeguarding vulnerable adults.

Systems to monitor and improve care required some improvement including completing the clinical audit cycle. Staff had not received appraisals but told us they had supervision.

The service had some services in place to respond to the needs of the different population groups who used the practice. For example, patients diagnosed with depression were referred to a weekly counselling service at the practice and we noted that a Saturday surgery was held for patients with long term conditions.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems in place to ensure patients received safe care, although some were still relatively new. All of the practice GPs had undertaken children protection and vulnerable adults safeguarding training within the last three years including advanced level child protection training. A system for reporting and investigating significant events had recently been introduced.

Arrangements were in place for the prevention and control of infection and the management of medicines. This included policies and a lead for infection prevention and control. Training records showed that all GPs had undertaken basic life support (BLS) training within the last twelve months and the practice had medicines to respond to medical emergencies.

Are services effective?

The practice had some systems in place to provide effective care, but they required further development. Best practice guidance including the National Institute for Health & Care Excellence (NICE) guidance was used to inform patient care. Records showed that the practice had undertaken five clinical audits. However, two of the audits were not dated. The practice worked with other services to provide care to patients and multidisciplinary meetings were held to discuss patient's care including those with long term conditions.

Staff had not had annual appraisal meetings and although we were told they had supervision, there was no documentary evidence to support this.

The practice promoted a healthy lifestyle through, for example, offering smoking cessation advice and healthy eating advice to pre-expectant mothers.

Are services caring?

The Department of Health 2013 GP Patient Survey highlighted that most patients were happy with how they were treated by staff. During our inspection, we noted that patient feedback was generally consistent with these findings. Patients also told us that they felt involved in decisions about their care and treatment. The practice had a chaperone policy and we saw that it was advertised in reception. However, staff had not received chaperone training. We observed staff interact with patients in a compassionate and respectful manner.

Summary of findings

Are services responsive to people's needs?

Many aspects of the service were responsive to patient's needs. The practice had a ramped entrance for wheelchair users and a hearing loop was available on the telephone system for people with hearing impairments. Interpreting services were available for patients for whom English was not their first language including British Sign Language.

Patients were offered a range of appointments from Monday to Friday with extended hours appointments on Monday and Friday evenings. They spoke positively about the appointment system and this was consistent with the results of the national 2013 GP Patient survey.

The provider had a complaints policy and procedure but no complaints had been made in the last twelve months. Learning from complaints was verbally shared with staff but this was not recorded.

Are services well-led?

Staff told us they felt valued and they felt the practice was well led, although we found some areas that required improvement. The practice had leads for the different aspects of governance but their roles and responsibilities were not documented. Meetings took place but these were not always recorded and the practice did not have a documented business continuity plan. Staff were aware of the future plans for the practice. Although staff had not had formal appraisal meetings, they told us that felt well supported in their roles. The practice had some systems in place to monitor and improve the quality of care. A Patient Participation Group (PPG) had recently been set up and members spoke positively about how the practice had listened to and addressed their suggestions for improving the service.

Summary of findings

The six population groups and what we found

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

Older people
The service was responsive to the needs of older people. Extended appointment times were available at the weekend and a ramped access was in place. Some treatment rooms were located on the ground floor. A local care home where several older patients resided, spoke positively about the practice's knowledge of patients and the willingness to undertake visits.

People with long-term conditions
The service was responsive to the needs of people with long term conditions, although we found areas for improvement. Patients with long term conditions were encouraged to regularly attend the practice so that their condition could be reviewed. We also saw that clinical audits had taken place.

Mothers, babies, children and young people
The practice was responsive to the needs of mothers, babies, children and young people. Administrative staff could describe possible types of abuse and how concerns would be escalated. GPs had undertaken advanced level child protection training.

The working-age population and those recently retired
The service was responsive to the needs of working age people and those recently retired. This included offering a range of appointment times during the evenings and early Saturday morning. Patients with long term conditions who worked away from home were advised to temporarily register with a GP near their place of work in care of an emergency.

People in vulnerable circumstances who may have poor access to primary care
The service was responsive to some of the needs of vulnerable patients and worked to ensure equality of access. Patients with a learning disability were offered extended appointment times. Interpreting services were offered in a range of languages including British Sign Language.

People experiencing poor mental health
The service was responsive to people experiencing poor mental health. This included liaison with mental health professionals and regular health care reviews.

Summary of findings

What people who use the service say

The recent National GP Patient Survey 2013 showed that the practice performed above the CCG average regarding helpfulness of receptionists (85%) and regarding the level of trust patients had in their GP (94%). However, the survey also showed that the practice performed below the CCG average for the percentage of patients who had to wait up to 15 minutes to be seen, after arriving for their appointment (22%).

During our inspection, we spoke with eight patients. They told us they felt safe and confident in the GPs, nurses and staff at the practice. They spoke positively about the service, describing the service provided as “excellent” and “exceptional.” Patients felt that their views were listened to and also that they were provided with sufficient information to make informed decisions about their health. They said the practice always looked clean and tidy when they attended their appointments.

We also spoke with a representative from a care home where the practice undertook home visits. Staff spoke positively about the senior GP and their patient centred approach to care and treatment. For example, we were told that the GP was accessible and that referrals were processed promptly.

We reviewed twenty two comments cards which had been completed by patients in the two week period before our inspection. The cards enabled patients to record their views on the service. Feedback was positive about the quality of care received.

Areas for improvement

Action the service MUST take to improve

Risk assessments for administrative staff who had not had a disclosure and barring service (DBS) check had not been carried out.

Action the service COULD take to improve

The practice was unable to evidence that it’s practice nurse had received an annual appraisal.

The practice did not offer an online appointment booking facility.

Records of non clinical staff members’ supervision meetings were not kept.

The practice did not have a formal process to share information and learning from complaints with all staff.

Staff had not undertaken chaperone training.

Clinical audits were carried out but the clinical audit cycle was not completed.

Bincote Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and GP. The team also included an Expert by Experience. The GP and Expert-by-Experience were granted the same authority to enter Bincote Surgery as the CQC Inspector.

Background to Bincote Surgery

Bincote Surgery is located in Enfield, close to the borough boundary with Barnet. It had approximately 5,900 patients registered at the time of our inspection.

Enfield is a suburban outer north London Borough. Census data shows an increasing population and a higher than average proportion of Black and Minority Ethnic (BME) residents. Life expectancy is 8.2 years lower for men and 6.3 years lower for women in the most deprived areas of Enfield than in the least deprived areas. The borough has a relatively high rate of long term unemployment and a high proportion of obese children. Rates of smoking during pregnancy are significantly better than the England average, as are the number starting breast feeding. Enfield has the fifth highest recorded prevalence of diabetes in London.

In addition to the two GP partners (one male, one female) and five locum GPs (one female, four male) there is a practice manager, practice nurse, health care assistant and reception/administrative staff. Bincote Surgery is a training practice and provides training for foundation doctors.

Bincote Surgery has elected to be a member of NHS Enfield Clinical Commissioning Group (CCG). The CCG is responsible for commissioning health services for the patients registered with its 54 member GP practices.

Why we carried out this inspection

We inspected this GP service as part of our new inspection programme to test our approach going forward. This practice 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.

Detailed findings

Before visiting, we reviewed a range of information we hold about the service including NHS Quality and Outcomes Framework (QOF) data and asked other organisations including NHS England, Enfield Clinical Commissioning Group (CCG) and Enfield Healthwatch to share what they knew about the service.

We carried out an announced visit on 29 May 2014 and 2 June 2014. During our visit we spoke with a range of staff including GPs, practice nurse, practice manager and reception staff. We also spoke with eight patients including an informal discussion with four Patient Participation Group (PPG) members. We observed how patients were being cared for and also looked at a range of policies and procedures including clinical audits and patient surveys.

Are services safe?

Summary of findings

The practice had systems in place to ensure patients received safe care, although some were still relatively new. All of the practice GPs had undertaken children protection and vulnerable adults safeguarding training within the last three years including advanced level child protection training. A system for reporting and investigating significant events had recently been introduced.

Arrangements were in place for the prevention and control of infection and the management of medicines. This included policies and a lead for infection prevention and control. Training records showed that all GPs had undertaken basic life support (BLS) training within the last twelve months and the practice had medicines to respond to medical emergencies.

Our findings

Safe patient care

Information obtained before our inspection indicated that the practice had not undertaken significant events reviews in the last twelve months. The practice told us that a significant events policy and reporting form had recently been introduced but that prior to its introduction, significant events analysis (SEA) took place at practice team meetings. Staff talked us through how they would use the new form to report incidents.

We were told that patient safety alerts were emailed to the practice manager from the Enfield CCG who then forwarded them to clinicians.

Learning from Incidents

A review of staff practice team minutes within the last twelve months confirmed that learning from incidents had taken place. Staff told us for example, that they had improved their medicines management protocols after a batch of vaccines had had to be disposed because the fridge door had been left open.

Safeguarding

The practice had a safeguarding policy for vulnerable adults and a child protection policy. The policy included local safeguarding contact details for the local CCG and local authority and these were also located in the practice reception. The senior GP was the safeguarding lead and records showed that all GPs had undertaken Level 1 (basic) children and vulnerable adults safeguarding training within the last three years. The practice nurse had undertaken Level 2 child protection training and GPs had undertaken the required Level 3 (advanced) child protection training.

The senior GP was able to provide examples of when they had contacted social services about a safeguarding concern. Minutes of recent practice meetings also showed that safeguarding issues were regularly discussed.

Monitoring safety and responding to risk

The practice set aside a number of emergency appointments for each GP each day in order to respond to patients who needed to be seen urgently. The practice also operated GP telephone triage to ensure patients were seen within a clinically appropriate period of time.

The senior GP told us that the practice shortly intended to recruit an assistant practice manager to address increasing

demand on the service. In the interim, we were told that the senior GP and salaried GP attended the surgery thirty minutes earlier each morning to undertake administrative tasks and support the practice manager. Records showed that this arrangement had been recorded in staff meetings.

We did not see evidence of a business continuity plan in place but the practice had arrangements to identify and respond to risk. After our inspection, we were advised that a plan had been in place since 2006 but this was not available on the day of our inspection. However, we were told a contract was in place to provide back up, should the IT system go down and staffing levels would be increased in the event of a pandemic. The practice was in the process of developing a succession plan to recruit GPs as the current ones retired.

Medicines management

The practice had a medicines management policy. Medicines storage and disposal and expiry dates were checked in line with their policy. The temperatures of the two fridges were regularly recorded to ensure they were within the required parameters. However, we also saw that one of the fridge temperatures was recorded daily and not twice daily in accordance with the practice policy. We were assured that twice daily checks would commence immediately.

Staff told us that the practice did not hold stocks of controlled medicines and that medicines were not routinely taken on GP home visits. We saw that the practice did not have a documented formulary (a list of standard medicines prescribed by clinicians at the practice). The Senior GP advised us that they were always available in person or by phone for support and guidance regarding medicines.

Cleanliness and infection control

The practice had an identified Infection Prevention and Control Lead who had received training within the last twelve months. During our inspection, we saw that the surgery reception, toilets, waiting room and treatment rooms were clean. One of the four treatment rooms had been refurbished. Records showed that the surgery had recently undertaken an infection prevention and control (IPC) audit to identify where improvements were required. We looked at the subsequent action plan and we were advised that the remaining three treatment rooms would be refurbished by December 2014.

Clinical waste awaiting collection was securely stored outside. Liquid soap dispensers and paper towels were provided in all clinical areas. The room used for minor surgical procedures had appropriate flooring which could be easily cleaned. Patients spoke positively about the cleanliness of the practice.

The practice nurse had received infection prevention and control training. They explained infection prevention measures undertaken prior to minor surgery. The practice nurse also knew what to do in the event of a needle stick injury to minimise the risk of infection. We saw that this was consistent with the provider's needle stick injury policy. We looked at a selection of surgical dressings and saw that they were within their expiry date.

Staffing and recruitment

The practice had recruitment systems in place. For example, we saw that GPs' Disability Barring Service (DBS)/Criminal Records Bureau (CRB) checks were on file. We were later advised that the practice nurse had also undertaken DBS/CRB checks. However, the practice was unable to demonstrate that administrative staff members had undergone DBS/CRB checks as part of their pre-employment checks. Additionally, there was no evidence that this decision was based upon a risk assessment of the different responsibilities and activities of each administrative role. After our inspection, we were advised that the practice was in the process of applying for DBS/CRB checks for all administrative staff.

Dealing with Emergencies

Training records showed that all GPs had undertaken basic life support (BLS) training within the last 12 months, with some additionally receiving BLS in children and infants. Emergency medicines (used in the event of an epileptic fit or asthma attack) were centrally accessible and within their expiry date. Emergency oxygen was available and had been regularly checked.

Equipment

Practice equipment and facilities were up to date and had been calibrated by an external company within the last six months. This included weighing scales, blood pressure monitors, nebuliser (a device used to administer medication in the form of a mist) and cauterisation equipment (used to remove skin lesions during minor surgery).

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice had some systems in place to provide effective care, but they required further development. Best practice guidance including the National Institute for Health & Care Excellence (NICE) guidance was used to inform patient care. The practice used data from the Quality and Outcomes Framework to benchmark their practice. Records showed that the practice had undertaken five clinical audits. However, two of the audits were not dated and the audit cycle was not completed.

The practice worked with other services to provide care to patients and multidisciplinary meetings were held to discuss patient's care including those with long term conditions.

Staff had not had annual appraisal meetings and although we were told they had supervision, there was no documentary evidence to support this.

The practice promoted a healthy lifestyle through, for example, offering smoking cessation advice and healthy eating advice to pre-expectant mothers.

Our findings

Promoting best practice

Clinical staff kept up to date with best clinical practice through continuing professional development and reviews of NICE updates. The senior GP told us that they held regular discussions with GPs to discuss latest Department of Health best practice and national guidance. The practice manager told us that they regularly forwarded CCG clinical email updates and that these included NICE guidance. Recent email updates had covered medical emergencies equipment and influenza.

Management, monitoring and improving outcomes for people

Records showed that the practice had initiated five clinical audits covering conditions such as depression and chronic kidney disease. Three of the audits were within the last two years, however two were not dated. Additionally, there was no evidence that follow up audits had taken place to confirm that recommendations had been implemented and any improvements recorded. We were told that a clinical audit protocol would be introduced from July 2014. Shortly after our inspection we were further advised that the five clinical audits would be revisited and fully completed.

The practice used the Quality Outcome Framework (QOF) to benchmark their practice and target improvements as appropriate for example regarding improving care and support to patients with diabetes.

Records also showed that GPs met with other health professionals to monitor patient care and improve outcomes. This included discussions with health visitors and district nurses.

Patients identified with a long term condition such as chronic kidney disease were placed on disease registers and regular review appointments were made with the nurse in accordance with best practice guidance.

We contacted a local care home where several patients resided. The manager spoke positively about the senior GP's knowledge of patients' health; particularly those living with long term conditions. The manager attributed this to the GP's weekly visits and their readiness to discuss

Are services effective?

(for example, treatment is effective)

patients over the phone or to undertake home visits. The manager added that the GP's ongoing involvement meant that changes in a patient's condition were promptly detected.

Patients with a long term condition who regularly worked away from home were advised to temporarily register with a GP near their place of work so that their medical history was readily available in case of a medical emergency.

Staffing

Staff told us that they felt supported in their roles and that regular informal supervision meetings took place. However, these were not documented. We were also told that annual staff appraisals did not take place, which meant there was no formal process for performance review and identifying objectives / training needs for the coming year. After our inspection, we were advised that an appraisal date had been set for the practice nurse and also that the practice would start documenting staff supervision meetings.

We did not see evidence of training records or supervision meetings for administrative staff. The practice nurse had recently started at the practice and undergone a structured induction programme.

The senior GP had recently undertaken revalidation with the salaried GP revalidation due for December 2014.

Working with other services

We were told that the senior GP worked one morning per week as an Associate Specialist at a local hospital providing specialist dermatology care. They advised us that they discussed patient referrals at the hospital's weekly multi-disciplinary meetings and that this helped standardise treatment approaches at the practice.

We saw evidence of other GPs' attendance at multi-disciplinary team meetings where patients with long term conditions were discussed with health visitors and district nurses; and care plans developed. However, we were told that although these meetings regularly took place, they were not always documented. We were assured that patient notes were updated as appropriate.

GPs told us that they had a good working relationship with the local community diabetes team and that they were readily available to provide specialist advice and support regarding diabetic patients.

The practice had a mental health lead and GPs liaised with local community mental health teams and clinical psychologists and patients were offered regular health care reviews.

The senior GP told us that the practice also had good working relationships with palliative care nurses (clinical specialists in end of life care) and that they routinely signposted patients for specialist advice and support as necessary.

Health, promotion and prevention

The health care assistant and practice nurse were responsible for health promotion activity including smoking cessation and child immunisations. The practice nurse told us that the smoking status of patients was recorded when they registered and they were offered smoking cessation advice. Health promotion was displayed on a reception TV and there was also extensive information in leaflet form. The practice web site contained a healthy living page.

The practice provided a well women clinic and also made a room available for an external clinical psychologist to deliver a counselling service for patients experiencing stress at work.

Are services caring?

Summary of findings

The Department of Health 2013 GP Patient Survey highlighted that most patients were happy with how they were treated by staff. During our inspection, we noted that patient feedback was generally consistent with these findings. Patients also told us that they felt involved in decisions about their care and treatment. The practice had a chaperone policy and we saw that it was advertised in reception. However, staff had not received chaperone training. We observed staff interact with patients in a compassionate and respectful manner.

Our findings

Respect, dignity, compassion and empathy

Before our inspection, we looked at national 2013 GP Patient Survey results. We noted that 85% of patients fed back that receptionists were helpful and that 90% fed back that the last GP they saw or spoke to was good at listening to them. We also noted that 68% of patients were satisfied with the level of privacy when speaking to receptionists at the surgery. This was above the local CCG average.

Patients were able to discuss their treatment, medical history and other personal matters in private in treatment rooms. Reception telephones were located away from the desk to maintain privacy. The reception area was adjacent to the waiting room which meant that privacy was limited. However, we were advised that facilities were available if a patient wanted to speak in confidence.

During our inspection, we spoke with four members of the Patient Participation Group (PPG). The group had recently been set up to involve patients in decisions about how care was delivered. Members spoke positively about their respective GPs; referring to them as “kind.” They also spoke positively about the practice manager and the reception staff. They felt they were kind and treated them with dignity and respect.

The practice manager told us that reception staff had not received training in customer care or in dealing with challenging patients but that this was being organised. During our inspection, we observed that staff interacted with patients in a personable, compassionate and respectful manner. We additionally spoke with four individual patients who were all positive about their interactions with staff. Also, none of the twenty two patients who completed our comments cards gave negative feedback about how they were treated by staff.

The practice had a chaperone policy and this was displayed in the reception. Patients confirmed that chaperones were offered. Reception staff and if necessary the practice manager undertook chaperone duties although we noted that staff training had not taken place. However, after our inspection, we were advised that staff chaperone training would shortly take place.

Are services caring?

Involvement in decisions and consent

Patient feedback was positive regarding patient involvement in decisions and consent. This was also the case regarding choice and location of treatment (referrals). One patient living with a long term condition told us that the information they received had empowered them to make informed decisions about their health. When we met with patient participation group members, they also shared this view. GPs' continuing professional development included Mental Capacity Act 2005.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Many aspects of the service were responsive to patient's needs. The practice had a ramped entrance for wheelchair users and a hearing loop was available on the telephone system for people with hearing impairments. Interpreting services were available for patients for whom English was not their first language including British Sign Language.

Patients were offered a range of appointments from Monday to Friday with extended hours appointments on Monday and Friday evenings. They spoke positively about the appointment system and this was consistent with the results of the national 2013 GP Patient survey.

The provider had a complaints policy and procedure but no complaints had been made in the last twelve months. Learning from complaints was verbally shared with staff but this was not recorded.

Our findings

Responding to and meeting people's needs

The practice had a ramped entrance for patients who used wheelchairs. The reception area was wide enough to accommodate a wheelchair. There was a disabled toilet on ground floor level and also the capacity to see patients in ground floor treatment rooms if required.

A hearing loop was available on the telephone system for patients with a hearing impairment. One patient with a hearing impairment told us that the GP maintained eye contact during consultations so that they could lip read. The waiting room had a visual display to ensure that patients with a hearing impartment did not miss their appointment being announced.

GPs told us that patients with a learning disability or sensory impairment were routinely offered extended appointments. The practice nurse told us that the practice was proactive in contacting and arranging annual health check appointments for patients with a learning disability.

The practice was able to accommodate patients' preference for a male or female GP and a chaperone service was also advertised in reception.

A telephone interpreting service was regularly used and we were told that a face to face interpreting service was also available. The senior GP spoke Tamil and was able to engage with patients from the Sri Lankan community for whom English was not their first language. The demographic of the borough did not indicate a large Tamil population but we were told that patients from the Tamil community registered at the practice because the senior GP was well known amongst the north London Tamil community. The senior GP told us that where other patients presented with limited English, an interpreting service was used as opposed to a friend or relative, so as to

Are services responsive to people's needs?

(for example, to feedback?)

ensure impartial interpreting. However, in order to tackle social exclusion, such patients were signposted to ESOL (English for Speakers of Overseas Languages) classes via the local Citizens Advice Bureau.

The practice also offered extended appointment times for older patients at the end of Saturday surgery and out of hours appointments at a specific time for patients experiencing poor mental health. Patients diagnosed with depression were referred to a counselling service which the practice hosted.

Access to the service

The National GP Patient Survey 2013 noted that 83% of patients were satisfied with the surgery's opening hours and that 98% stated that the last appointment they got was convenient. The practice's performance in these two areas was above average for the local CCG area.

Patients were offered a range of appointments at the practice from Monday to Friday depending on their needs with extended hours appointments on Monday and Friday evenings, early mornings and Saturday mornings. The practice offered extended appointment times for older patients at the end of Saturday surgery and we were told that home visits were also offered. Patients spoke positively about how quickly they were able to book an appointment. Comment card feedback was generally positive although some feedback highlighted delays in being offered an appointment if the patient wanted to see the GP of their choice.

Many patients who took part in the national 2013 GP Patient Survey fed back that they had to wait too long to be seen by their GP when they arrived for their appointment. The practice's performance on this indicator was worse than the local CCG average and during our inspection, we discussed this issue with patients. They told us that delays did occur but attributed this to the thorough nature of GP consultations.

The practice manager showed us quotes that had been obtained for a new telephone system which aimed to improve how patients could make appointments and request repeat prescriptions. It was anticipated that the new phone system would be in place by September 2014.The practice did not have an on-line booking system although after our inspection, we were advised that this was something that the practice was working towards.

Concerns and complaints

The practice had a complaints policy and procedure and these were advertised in the waiting room. We were told that no written complaints had been received in the last twelve months. We were further told that when a patient made a verbal complaint the practice manager contacted the patient and had been able to address their concerns. Patients we spoke with were not aware of the practice complaints policy but told us that if they had a concern, in the first instance they would contact the practice manager.

We were told that lessons learnt from complaints were shared informally with staff but this was not recorded. One GP fed back that following patient complaints, the waiting room seating had been replaced. After our inspection, we were advised that complaints would be formally discussed at future practice meetings.

Are services well-led?

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

Summary of findings

Staff told us they felt valued and they felt the practice was well led, although we found some areas that required improvement. The practice had leads for the different aspects of governance but their roles and responsibilities were not documented. Regular clinical and multidisciplinary meetings took place but these were not always recorded and the practice did not have a documented business continuity plan.

Although staff had not had formal appraisal meetings, they told us that felt well supported in their roles and were aware of the future plans for the practice. The practice had some systems in place to monitor and improve the quality of care.

A PPG had recently been set up and members spoke positively about how the practice had listened to and addressed their suggestions for improving the service.

Our findings

Leadership and culture

The senior GP told us that there was no hierarchy at the practice and that they tried to be supportive. During our inspection, we saw that the senior GP's interactions with staff were professional yet personable. Clinical and administrative staff told us the practice was well led and that it had an open culture where issues and concerns could be discussed. When we looked at the senior GPs evaluation feedback received by placement GP trainees at the practice, we saw that they had rated the practice as "excellent" regarding "feeling able to ask the questions that you wanted."

Governance arrangements

There were clinical governance arrangements in place with identified lead clinicians for different areas for example infection control and medicines. However, although we were advised that the senior GP was practice lead for training, risk management and data quality, we did not see documentation regarding clear roles and responsibilities.

Systems to monitor and improve quality

The practice had a range of meetings where quality and safety were discussed including weekly internal clinical meetings and ad hoc multidisciplinary meetings with GPs and other local clinicians. However, we saw that these meetings were not always formally recorded. The practice had recently introduced a significant events protocol and although clinical audits had been carried the audit cycle wasn't completed. out. Informal peer review took place through GP attendance at locality meetings.

Patient experience and involvement

The PPG had been set up within the last six months and patients told us the proposed new phone system was an example of how patient views had been listened to and used to shape how the service was delivered.

Staff engagement and involvement

Staff told us they felt valued and that their views were regularly sought at team meetings. The senior GP told us that the practice was planning to relocate and that he was planning to appoint two new partners and retire shortly thereafter. When we spoke with staff, they were aware of these plans. We were told that the practice had a whistle blowing policy for staff to report concerns in confidence.

Are services well-led?

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

Learning and improvement

Administrative staff told us that they felt supported in their roles. The practice nurse also told us she felt supported in her role. Staff had supervision meetings but these were not documented. All staff were up to date regarding mandatory training such as basic life support and fire training.

Identification and management of risk

We did not see evidence of a business continuity plan in place but the practice had arrangements to identify and respond to risk. After our inspection, we were advised that a plan had been in place since 2006 but this was not available on the day of our inspection. We were told a contract was in place to provide back up should the IT system go down and staffing levels would be increased in the event of a pandemic. The practice was in the process of developing a succession plan to recruit GPs as the current ones retired. Systems to record and investigate significant events had recently been introduced.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The service was responsive to the needs of older people. Extended appointment times were available at the weekend and a ramped access was in place. Some treatment rooms were located on the ground floor. A local care home where several older patients resided, spoke positively about the practice's knowledge of patients and the willingness to undertake visits.

Our findings

The practice had some arrangements in place to meet the needs of older patients. They included ramped access with hand rails for support and the practice surgery website allowing people to increase the text size.

The manager of a local care home, where several patients lived, spoke positively about the GP's on going knowledge of patients and how this facilitated early detection of changes in condition of patients with dementia and other long term conditions.

We were advised that if an older patient had an unplanned hospital admission, staff discussed the reason for the admission because often, the matter could be dealt with by the practice. We were also told that the practice had good working relationships with local consultant psychiatrists (older people). Staff added that the practice offered extended appointment times for older patients at the end of Saturday surgery. Home visits were offered and we were also advised that patients over 75 had a named GP.

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

Patients with long term conditions were encouraged to regularly attend the practice so that their condition could be reviewed. We also saw that clinical audits had taken place for diabetes and chronic kidney disease.

Our findings

We saw evidence of doctors' attendance at multi-disciplinary meetings, where patients with long term conditions were discussed with district nurses and other clinicians. However, not all meetings had been documented.

The senior GP told us that the practice's Saturday surgery focused on chronic disease management and that the practice was currently recruiting a second practice nurse to manage increasing demand for the service.

A patient with a long term condition told us that their GP had empowered them with sufficient information to manage their condition. Comment card feedback was also positive in this respect.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice was responsive to the needs of mothers, babies, children and young people. Administrative staff could describe possible types of abuse and how concerns would be escalated. GPs had undertaken advanced level child protection training.

Our findings

Services for mothers, babies, children and young people included weekly ante natal clinics, child immunisations, sexual health and a well woman clinic. GPs had undertaken the required level 3 (advanced) child protection training.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The service was responsive to the needs of working age people and those recently retired. This included offering a range of appointment times during the evenings and early Saturday morning. Patients with long term conditions who worked away from home were advised to temporarily register with a GP near their place of work in care of an emergency.

Our findings

Patients of working aged and those recently retired we spoke with were positive about how staff treated them when they phoned to make an appointment. Patients with a long term condition who regularly worked away from home were advised to temporarily register with a GP near their place of work, so that their medical history was readily available in case of a medical emergency.

The practice hosted a weekly counselling service which provided advice and support on a range of issues including stress at work. We were told that the practice had clinical leads for minor surgery (including sports related injuries), family planning and sexual health.

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

The service was responsive to some of the needs of vulnerable patients and worked to ensure equality of access. Patients with a learning disability were offered extended appointment times. Interpreting services were offered in a range of languages including British Sign Language.

Our findings

The service was responsive to the needs of some vulnerable patients and worked to ensure equality of access. This ranged from patients with a learning disability being offered extended appointment times to the GP of a patient with a hearing impairment positioning themselves during consultation, so that the patient could lip read more easily. Interpreting services were offered in a range of languages including British Sign Language.

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

The service was responsive to people experiencing poor mental health. This included liaison with mental health professionals and regular health care reviews.

Our findings

The practice had a mental health lead and GPs also liaised with local community mental health teams. Patients were offered regular health care reviews. Urgent referral pathways were in place for patients who were experiencing an acute episode of their illness. Patients diagnosed with depression were referred to a counselling service which the practice hosted. Staff demonstrated an understanding of the Mental Capacity Act 2005 and their obligations to patients who lacked capacity.

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
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers How the regulation was not being met: The provider failed to ensure that criminal record certificates or other such information as is appropriate was available in respect of persons employed for the purpose of carrying on a Regulated Activity. Specifically, the provider was unable to evidence that its decision not to carry out Disclosure and Barring service (DBS) checks for administrative staff, had been risk assessed. Regulation 21(b)