Trinity Avenue Doctors 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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Overall summary

Trinity Avenue Doctors Surgery is a small general practice (GP) service located in the London Borough of Enfield. NHS Enfield Clinical Commissioning Group (CCG) is a membership organisation of 54 local GP practices, of which Trinity Avenue is one. Enfield CCG is responsible for commissioning health services for a population of around 310,000 people in Enfield.

Trinity Avenue provides patients with a primary care service. The practice is situated in two semi-detached houses on a residential street. The practice is registered with the Care Quality Commission (CQC) as a partnership with two GPs, one of whom is the practice's registered manager.

All the patients we spoke with were complimentary about the service they received. We received twenty three comments cards completed by patients prior to our visit. The responses demonstrated patients were consistently pleased with the service they received.

The regulated activities carried out by the practice were diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury. We found the practice provided a safe service. Mechanisms were in place to report and record safety incidents, concerns, near misses and allegations of abuse. However patients were exposed to some risk because the process for checking medication was not sufficient. We have asked the practice to take action to address this.

The service was effective at planning care and treatment and meeting patient's needs. Patients said the practice provided a caring service. We saw good interactions between patients and staff and patient's privacy and confidentiality were protected. Services were organised so as to meet patient's needs.

The service was well led. There were clear lines of accountability and the leadership culture was open and supportive. Improvements could be made by practice ensuring staff were able to articulate the values and ethos of the practice. The patient participation group was highly motivated and involved however they could be used more effectively.

The service met the needs of groups such as older people, people with long term conditions, mothers, babies, children and young people, the working age populations and those recently retired. Services for those patients experiencing poor mental health could be improved. Processes were in place to ensure people with long term conditions were supported to manage their conditions and received regular health reviews. All practice staff worked together as a team to provide patients with an effective and good quality service. Patients we spoke with and comment cards we received showed patients were happy with the quality of care and treatment they had received. There was good access to appointments with patients telling us they were always able to get appointments at times that suited them.

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 a good track record on safety. Mechanisms were in place to report and record safety incidents, concerns, near misses and allegations of abuse. Staff were aware of the process to report any such incidents. Patients we spoke with felt safe using the service. All staff had received training to identify and report any concerns about abuse. Mechanisms were in place for the reporting of safety incidents. Staff were aware of the processes to follow to keep patients safe. The service was able to respond to medical emergencies.

Systems were in place to store and monitor medication in the practice required improvement. However we noted the stock of one vaccine was almost one month out of date. This meant patients were at risk of receiving vaccines that were not safe to use.

There was sufficient staff to respond to busy periods and to meet patient's needs.

There were suitable processes in place to protect patients from the risks of cross infection.

Are services effective?

Care and treatment was being delivered in a way that achieved good outcomes, promoted good quality of life and was line with current published best practice. Patients' needs were met in a timely manner. The practice had measures in place to ensure adherence to best practice and recognised guidance.

There were processes in place to ensure informed consent was sought before care and treatment was given.

Are services caring?

All the patients we spoke with during our inspection said they were treated with compassion, kindness, dignity and respect. They said they were involved with their care and supported to make informed decisions and give informed consent. We saw good interactions between patients and staff and patient's privacy and confidentiality were protected.

Are services responsive to people's needs?

The practice was organised so as to meet patient's needs. They planned and provided appropriate services for different groups such as older people and people in vulnerable circumstances such as those with a learning disability. Various weekly clinics were operated

Summary of findings

to meet the needs of different groups to support those with long term conditions. The practice took account of patient's language needs. Patients were able to access the service when they needed to. There was a complaints procedure in place.

Are services well-led?

Services were well led. The service had a stable team of staff , all of whom had been at the practice for a number of years. There were clear lines of accountability and the leadership culture was open and supportive. Staff roles were clearly defined and each member of staff knew what was expected of them. Improvements could be made by formalising plans for leadership development and succession. The patient participation group was highly motivated and involved however they could be used more effectively effectively as a conduit for patient's views and health promotion within the local community.

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 practice was responsive to the needs of older people. There was emphasis on continuity of care and arrangements to ensure those who were house-bound received sufficient care and support. Processes were in place to ensure over those aged 75 received regular health reviews.

People with long-term conditions
The practice was responsive to the needs of those with long term conditions. People with long term conditions such as diabetes, coronary heart disease (CHD) or osteoporosis were supported with annual, or when required health checks and medication reviews. Repeat prescriptions were limited to a three months' supply. Anti-depressants were prescribed for a maximum of one month at a time. This helped to ensure effective monitoring of patients on long term medication.

Mothers, babies, children and young people
The practice was responsive to the needs of mothers, babies, young children and young people. Processes were in place to ensure a full set of childhood vaccinations were offered and were properly recorded. The GPs were aware of the health related issues that affected young people and had measures in place to address these. Clinics were operated to address the particular health needs of this group.

The working-age population and those recently retired
The practice was responsive to the needs of working age people and those recently retired. The practice offered bookable appointments which included early mornings and late afternoons.

Telephone consultations were also available and patients we spoke with had no problems contacting the practice by telephone.

People in vulnerable circumstances who may have poor access to primary care
The practice was responsive to the needs of people in vulnerable circumstances. Annual health checks were carried out for patients with learning disabilities using a recognised tool.

Summary of findings

People experiencing poor mental health
The practice was conscious of the needs of people experiencing poor mental health. However their involvement with the local mental health team required improvement.

Summary of findings

What people who use the service say

All the patients we spoke with during the inspection were very complimentary about the service they received. They said they consistently received a good service and praised the practice for providing a traditional family GP practice. They said this ethos suited the needs of the local community. Comment cards completed by patients described positive experiences with the practice and stated that they were able to gain access to the service when they needed to and were treated with respect and dignity.

Patients said they felt safe using the practice and had confidence in the GPs and nurse. Many of the patients we spoke with had been using the practice for over 25 years and spoke positively about the standard, responsiveness and continuity of care they received. Patients said their views were listened to and that clinicians explained their treatment to them. Patients told us they were involved in decisions about their care and treatment and were able to ask questions where they needed to. They said the practice always looked clean and tidy when they attended their appointments.

Areas for improvement

Action the service MUST take to improve

- The process for checking medication must be improved to ensure it is sufficiently robust to protect people from the risk of receiving unsafe medication.

Action the service COULD take to improve

The provider could further demonstrate continuous service improvement by:

- Using the patient participation group more effectively as a conduit for patient's views and health promotion within the local community
- Formalising plans for leadership development and succession

Trinity Avenue Doctors Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspection team also included a GP and an expert by experience.

Background to Trinity Avenue Doctors Surgery

Trinity Avenue Doctors Surgery is a general practice (GP) service. It provides a primary care service for around 2500 patients in the London Borough of Enfield. NHS Enfield Clinical Commissioning Group (CCG) is a membership organisation of 54 local GP practices, of which Trinity Avenue is one. Enfield CCG is responsible for commissioning health services for a population of around 310,000 people in Enfield.

Census data shows an increasing population and a higher than average proportion of Black and Minority Ethnic residents. 38.8% of the population belong to non-white minorities which is more than three times higher than the England average (12.3%). 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 Enfield population is proportionally younger than the England average – higher percentages of the population are under the age of 40.

Services are provided by two full time GPs and a part time practice nurse. The service is responsible for providing primary care The practice had operated from the same premises for a number of years with both GPs and the practice nurse there for over 25 years. A phlebotomist also operated from a room on the premises one morning a week.

The practice was open from 08.30 am to 6pm on all weekdays except Thursdays when it closed at midday for training, cleaning and meetings. On arrival at the practice patients were able to check in either at reception or using a check-in machine in the waiting area. This machine had two language options; English and Turkish.

The practice had arrangements in place for patients to receive care and treatment outside of its normal opening hours. This was through a local out of hours GP service accessed via the NHS 111 service.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward.

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?

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We reviewed 23 comments cards where patients and members of the public and staff shared their views and experiences of the service.

We carried out an announced visit on 28 May 2014. During our visit we spoke with a range of staff (GPs, the practice nurse and receptionists) and we also spoke with the phlebotomist. We spoke with patients who used the service and their carers and/or family members. We reviewed CQC comment cards completed by patients. We also spoke with representatives of the practice's patient Participation group (PPG). We looked at the practice's policies, procedures and some audits. We also looked at meeting minutes.

We also reviewed information we held and received about the service in advance of the inspection. This included from various sources such as the Clinical Commissioning Group (CCG), NHS England and Healthwatch.

Are services safe?

Summary of findings

The practice had a good track record on safety. Mechanisms were in place to report and record safety incidents, concerns, near misses and allegations of abuse. Staff were aware of the process to report any such incidents. Patients we spoke with felt safe using the service. All staff had received training to identify and report any concerns about abuse. Mechanisms were in place for the reporting of safety incidents. Staff were aware of the processes to follow to keep patients safe. The service was able to respond to medical emergencies.

Systems were in place to store and monitor medication in the practice required improvement. However we noted the stock of one vaccine was almost one month out of date. This meant patients were at risk of receiving vaccines that were not safe to use.

There was sufficient staff to respond to busy periods and to meet patient's needs.

There were suitable processes in place to protect patients from the risks of cross infection.

Our findings

Safe Patient Care

Mechanisms were in place to report and record safety incidents, concerns, near misses and allegations of abuse. Staff were aware of the process to report any such incidents. The practice had an accident book in which any incidents and accidents were recorded.

Cleanliness & Infection Control

The premises were visibly clean and pleasant. The service had an infection control policy, which set out the steps to be taken by staff to ensure patients, and staff were protected from the risks of cross infection. The practice manager was the infection control lead. Staff were responsible for all cleaning tasks and cleaning was carried out twice a day. Extensive cleaning was carried out once a week on a Thursday afternoon when the practice was closed. Alcohol gel dispensers were available and were full. All sinks had a supply of liquid hand soap and disposable hand tissue.

Medicines Management

Systems were in place for the handling, administration and storage of medicines. The practice nurse was responsible for managing and checking the medicines. In her absence this was done by the receptionists. The fridge temperature was checked daily by the practice nurse. If it was found to be out of range, this was reported to the GP who would then decide what action should be taken. Vaccines were checked monthly. We noted the stock of one vaccine was almost one month out of date. This meant patients were at risk of receiving vaccines that were not safe to use. The practice nurse told us she had been on holiday at the end of April 2014 and this had been overlooked. These vaccines were immediately removed from the fridge for disposal. The process for checking medication when the practice nurse is unavailable required review to ensure patients were not at risk of receiving unsafe medication.

Reliable safety systems and processes including safeguarding

Reliable systems were in place to minimise risks to patient safety. Repeat prescriptions were requested in person or in writing 48 hours in advance. Special arrangements were in place to support those who were house-bound who could make this request by telephone. Prescription medication could also be delivered to patients at home where

Are services safe?

required. Repeat prescriptions were limited to a three months' supply. Anti-depressants were prescribed for a maximum of one month at a time. This helped to ensure effective monitoring of patients on long term medication.

Staff had received training in child protection and safeguarding vulnerable adults. They were able to identify and respond appropriately to signs or concerns about abuse. Contact details for the Clinical Commissioning Group's (CCG) safeguarding team were available. Staff were able to provide recent examples of safeguarding concerns that had been appropriately reported.

Learning from Incidents

The last recorded incident was two years ago. It concerned a phlebotomist provided by a local hospital who was noticed not to be wearing gloves. This was reported in an open and transparent way and managed in a way that ensured any risks to patients and others were minimised. Any incidents that occurred were discussed at monthly staff meetings to ensure lessons learned were shared with all staff. This was demonstrated in the minutes of monthly staff meetings.

Monitoring Safety & Responding to Risk

Staffing levels were maintained at a level that ensured patient's needs were met. There were sufficient numbers of non-clinical staff to ensure telephone calls were answered immediately and patients arriving at the service were attended to quickly. Patients we spoke with said they were always able to get an appointment when they required one, including the same day in the case of emergencies. The practice had contingency plans in place in case of an emergency where the premises could not be used. The practice had a mutual agreement with another local practice to share premises in such circumstances.

Dealing with Emergencies

The service was able to respond to medical emergencies. They received a new first aid box on the day of our inspection. The GPs had access to an emergency bag. This contained the necessary equipment and drugs to attend to a patient in the event of an emergency. Drugs and equipment were available for the treatment of anaphylaxis. Records showed all staff received training in Basic Life Support which was updated regularly, depending on each staff member's role within the practice. A defibrillator (a device which delivers an electrical shock to the heart) was available for use and records showed this was checked annually to ensure it was in good working order. There was no provision for oxygen at the practice. The GP told us the ambulance service was efficient and would be called in the event of an emergency where oxygen was required. Fire alarm and extinguisher checks were conducted regularly and all appliances were tested every five years to ensure they were safe.

Staffing & Recruitment

We spoke with two of the four reception staff. Both had worked at the practice for about four years. Two receptionists worked in the morning and another two in the afternoon. As well as answering telephone calls and attending to patients at reception they also had filing and scanning duties and repeat prescriptions. They told us there were particularly busy periods such as Monday mornings, however they were able to cope with the volume of calls and patients attending the practice. Staff said they were able to cover for each other for both planned and unplanned absences.

Clinical staff consisted of two GPs and a practice nurse. Both GPs and the practice nurse had been at the practice for over 20 years. All staff told us there were sufficient staff to meet patient's needs and respond to busy periods. Patients we spoke with said they were satisfied with staffing levels (both clinical and non-clinical) and believed there were enough staff to respond to their needs.

Records showed all staff had undergone background checks through the Disclosure and Barring Service (DBS).

Are services effective?

(for example, treatment is effective)

Summary of findings

Care and treatment was being delivered in a way that achieved good outcomes, promoted good quality of life and was line with current published best practice. Patients' needs were met in a timely manner. The practice had measures in place to ensure adherence to best practice and recognised guidance.

There were processes in place to ensure informed consent was sought before care and treatment was given.

Our findings

Promoting Best Practice

GPs and nurses were aware of The National Institute for Health and Care Excellence (NICE) guidelines. If faced with complex clinical issues, they were able to access guidance online. GPs attended locality meetings where clinical updates, guidelines and protocols were discussed. They attended monthly peer review meetings where any unusual or challenging cases could be discussed. One GP said they would discuss referrals at the meetings to compare referral practice with other
GPs.

The practice had developed some of its own clinical guidelines and protocols where good practice had been identified to ensure this was incorporated into patient's care. Examples of this were around urinary tract infections and atrial fibrillation. Another example related to childhood immunisations. The practice recorded the batch number, date of expiry, site of injection on the computerised records, in the child's Personal Child Health Record (Red Book) and the practice kept a written record.

GPs explained how they ensured patients were provided with sufficient information to give informed consent to treatment. They said they always respected the patient's choice. An example was given in respect of statins (medicines that can help lower the level of cholesterol in the blood). GPs said they would explain the pros and cons of taking the medicine. Some patients declined to take them and this was accepted as the patient's choice. The practice had a patient consent form which was signed by patients and scanned into their records. This form was also used to record consent for cervical smears, childhood immunisations and other procedures. For childhood vaccinations written consent was requested for each child for the full set of vaccinations. A signature was also required where consent was refused by the parent or guardian. If the vaccination was new, specific consent was sought to administer it.

Management, monitoring and improving outcomes for people

The practice had measures in place to improve the quality of care delivered by benchmarking and comparing activity at local and national levels. At a local level, one example related to antibiotic prescribing. The GP said they managed

Are services effective?

(for example, treatment is effective)

antibiotic prescribing by delaying prescription of antibiotics where appropriate or suggesting to the patient they will offer antibiotics in a day or two if the symptoms persist or worsen. In that situation the patient was told they would not have to make a further appointment. Clinical Commissioning Group (CCG) data we received prior to the inspection showed the practice had a lower than average prescribing rate. This was achieved by a use of a set repeat prescription policy. This set out the process to review repeat prescriptions at regular intervals to ensure they were still necessary.

The practice participated in the NHS cervical screening programme. This contributed towards early detection of cervical cancer and the prevention of early deaths.

Staffing

All staff had received training to support them in their roles. All clinical staff were registered with the relevant professional regulator. Staff files included contracts, appraisal forms, and suitable references and background checks.

The practice nurse said clinical staff were able to undertake on going training, for example, they attended a recent course in child obesity. They were able to attend mandatory training every year. Further opportunities for training were provided during the practice's staff meetings which took place every four to six weeks and were attended by all staff. There were mechanisms in place to ensure appropriate levels of supervision and appraisal of all staff. All staff received an annual appraisal by one of the GPs and we saw dates for appraisals were discussed in staff meetings. Individual objectives were set during appraisals and the following year, objectives were reviewed to see if they had been met. Staff members we spoke with said they received adequate training and support and could request further training when required.

Working with other services

The practice had regular integrated care meetings which were attended by GPs, health visitors, palliative care nurses, practice nurses, community matrons and district nurses. At the meetings any patients who would benefit from community services input were discussed. Examples included patients newly diagnosed with cancer. Practice nurses and palliative care nurses were made aware of such patients in advance in order to ensure effective co-ordination to meet patient's needs.

We spoke with a phlebotomist who worked at the practice one day a week. They described a successful and strong working relationship with the practice and said the practice staff were co-operative and helpful. This service also met patient's needs as they could have blood tests done on the same day they attended to see a clinician without having to go to the local hospital.

Information received from the practice's out of hours service was reviewed by the GPs and linked with the patient's records. Staff would contact the patient to make an appointment if follow up treatment or action was required.

Health Promotion & Prevention

Every new patient was initially seen by a GP for an assessment. During this consultation details of their medical history, allergies, lifestyle, occupations were taken. Details of immunisations were recorded and arrangements made to bring any missing immunisations up to date. Patients were given full medical check-ups which included basic blood tests. A machine was available in the waiting area which measured patient's weight and blood pressure. This could be used by any patient as and when required. Once the results were known a follow-up appointment was arranged to discuss any issues arising from the tests and to provide health promotion information on areas such as diet and exercise. Patients were also given details for online information sources. There was a large range of health promotion literature in the waiting area. This covered topics such as smoking cessation, flu prevention, cancer and dementia.

Where appropriate, the practice provided patients with information about local community groups that supported patients from specific ethnic backgrounds. This helped patients to access additional support to meet their health and social needs.

Are services caring?

Summary of findings

The service was caring. All the patients we spoke with during our inspection said they were treated with compassion, kindness, dignity and respect. They said they were involved with their care and supported to make informed decisions and give informed consent. We saw good interactions between patients and staff and patient's privacy and confidentiality were protected.

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said they were always treated with respect, dignity, compassion and empathy by all staff at the practice. They said they were treated as individuals and that staff showed them genuine concern and kindness. We saw effective interactions between patients and staff, which was relaxed whilst remaining professional and appropriate. Patient's privacy was respected. The waiting area was separate from the reception area meaning patients could speak to the receptionists privately. If greater privacy was required staff said they could take patients to empty rooms. Patients told us such a request would be accommodated if they asked. The glass window separating the receptionist's office and entrance area to the practice was closed when the receptionist was speaking on the telephone. This also protected patient's privacy and confidentiality.

The care provided was dignified and took into account the patient's physical support needs and their individual preferences, habits culture and faith. The premises supported disabled access and there was sufficient room to accommodate wheelchairs and other support equipment. On arrival at the practice patients were able to check in either at reception or using a check-in machine in the waiting area. This machine had two language options; English and Turkish.

Patients we spoke with said they were well supported by the practice staff at times of bereavement. The said staff wee caring and empathetic towards them. Reception staff said the GPs were notified of patients who were bereaved and they were contacted by the GPs. Patients we spoke to and responses on comment cards we received reflected this. Examples included a patient whose father and husband had died. They were contacted by the GP for support.

Involvement in decisions and consent

Patients said they were involved in planning their care and were supported to make their own decisions. Time was taken to explain patient's diagnosis and treatment and they felt able to ask questions and express their own opinions. Minutes of practice meetings showed clinical staff were aware to consider patient's competence to make decisions; for example about contraception. Most of the practice's

Are services caring?

patients with a learning disability came with their carer. Staff were aware to ensure they communicated with the patient as well as the carer and to involve them in decisions about their care.

Consent decisions were well documented. There was respect for patient choice, for example around statins. GPs explained the pros and cons of taking the medication.

Where patients declined to take them this was recorded in their notes. Decisions about consent for cervical smears and childhood immunisations were also recorded in patient notes. The practice had a consent form which was signed by the patient indicating if consent was being given or refused. This was scanned into the patient record.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was organised so as to meet patient's needs. They planned and provided appropriate services for different groups such as older people and people in vulnerable circumstances such as those with a learning disability. Various weekly clinics were operated to meet the needs of different groups to support those with long term conditions. The practice took account of their patients' language needs. Patients were able to access the service when they needed to. There was a complaints procedure in place.

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the patients it served and acted on these to design services. Examples of this were seen in the planning of services to meet the needs of older people. The service had a system for health reviews for those aged over 75. This check was done as and when patients attended or by recall. Staff were conscious of the particular needs of this group such as around mobility and hearing and planned their service accordingly. Annual health checks were carried out for patients with learning disabilities using a recognised tool.

Various weekly clinics were operated to meet the needs of different groups and to support those with long term conditions. Examples included asthma, diabetes and chronic obstructive pulmonary disease (COPD).

Baby/postnatal and well woman clinics were also run weekly. Some patients we spoke with attended these clinics and said the practice actively identified patients who would benefit from attending these clinics and staff would encourage them to attend.

Staff said they had access to interpreter or translation services for patients who needed it. Some reception staff were able to speak languages other than English but they were not used to interpret for patients during consultations.

Patients were offered alternative times to attend the practice, for example for diabetes or asthma checks, where those clinics were held during their hours of religious observation. This supported the needs of a large number of the practice's patients.

Access to the service

People said they were able to access the service at times that suited them. They said they were usually able to get appointments within a few days. In an emergency they would be accommodated on the same day. They were also able to contact the practice by telephone. Online booking was not available for appointments. Appointments were planned in such a way as to allow extra time for those with long term conditions or more complex needs. They were also planned to ensure appointments were available every day for people to book 48 hours in advance or on the day in

Are services responsive to people's needs?

(for example, to feedback?)

an emergency. The practice was open from 08.30am to 7pm on weekdays except Thursdays when it closed at 12pm. This supported working people to access the service.

Receptionists were able to describe the process for directing patients to a GP or a nurse and how decisions about urgency were made. If they had any doubts they were able to ask a doctor. They confirmed under certain circumstances they would tell the patient to call an ambulance on the GP's advice. Processes were in place to ensure all clinical staff were used effectively and to ensure people saw the most appropriate clinician to meet their needs. This helped patients to be able to access the service in a timely way.

Concerns & Complaints

The GPs met regularly with the Patients Participation Group (PPG). The PPG had six members and they met every three to four months. The GPs also attended the meetings. This was an opportunity to discuss any concerns about the quality of care. The members of the PPG we spoke with were complimentary about the practice and had no concerns or complaints. The practice had not received any patient complaints within the last year. There was a complaints policy available which detailed the complaints process and identified the relevant person who managed complaints and the time scales involved. Patients were asked to put complaints in writing where possible. One of the GPs who was also the practice manager managed all complaints.

Are services well-led?

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

Summary of findings

Services were well led. The service had a stable team of staff , all of whom had been at the practice for a number of years. There were clear lines of accountability and the leadership culture was open and supportive. Staff roles were clearly defined and each member of staff knew what was expected of them. Improvements could be made by formalising plans for leadership development and succession. The patient participation group was highly motivated and involved however they could be used more effectively as a conduit for patient's views and health promotion within the local community.

Our findings

Leadership & Culture

The clinical staff had worked at the practice for over 20 years. The practice nurse had also worked at that practice for over 20 years. The support staff team was stable. The practice did not have any specific articulated set of values however it was apparent that staff subscribed to the same informal set of values around providing the best service for patients. The practice recognised the importance of maintaining high standards and were conscious patients could leave the practice if they were dissatisfied.

The practice was conscious of the impact of changes in general practice and was concerned about future expectations such as possibly being required to be open seven days per week. They were unclear about how such changes would be implemented. They were aware of the need to plan for the future leadership of the practice but had no clear strategy in place.

The practice had considered the key issues affecting the future of health provision for patients and was formulating strategies to manage these. They had objectives in place, for example to increase care of the elderly and strengthen links with community services.

Governance Arrangements

The governance arrangements were straightforward given the small size of the practice. The GPs shared responsibility for governance and monitoring quality and performance. One of the GPs was also the practice manager and was therefore responsible for the day to day running of the practice. All staff at the practice had gone through the NHS Information Governance (IG) Toolkit online. The IG Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. Using this toolkit helped staff to be able to identify risks and ensure they were understood and managed.

Mechanisms were in place to report and record safety incidents, concerns and near misses. Staff were aware of the process to report any such incidents. Staff were able to discuss any incidents or concerns at regular practice meetings.

Patient Experience & Involvement

The practice had a very involved and motivated Patient Participation Group (PPG) who were keen to become more

Are services well-led?

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

involved in supporting the practice as a link between the practice and the wider patient group. A patient survey had been carried out in 2013. The responses were largely complimentary however one issue was raised concerning the phone lines. As a result an additional phone line was installed. The PPG were not involved in the annual patient survey process, nor did any practice events take place which they could support and use as an opportunity to meet with other patients. The PPG could be used more effectively to support the practice to improve patient experience and involvement.

Staff engagement & Involvement

Practice meetings were held regularly. These meetings were also used as an opportunity to deliver training. Staff said they were encouraged to put forward their own ideas about how to improve the service. Any lessons learned were shared and minutes of all meetings were made available for all staff. Staff had a book where they noted any issues that arose that needed to be discussed at the next meeting.

The management modelled and encouraged cooperative, appreciative, supporting relationships among staff. Reception staff said they were empowered to manage the rota themselves and to arrange cover for absences among themselves. They had set up processes to ensure effective communication between themselves and with the leadership. This helped to ensure patients' needs were met and the practice operated efficiently.

Learning & Improvement

Staff confirmed they received annual appraisals. They said this was an opportunity to review their performance over the previous year and to plan and agree targets for the year ahead. Staff said this was a useful process as they were able to reflect on what they had achieved and identify areas that required improvement.

Identification & Management of Risk

The practice ensured that any risks to the delivery of high quality care were identified and mitigated before they adversely impacted on the quality of care. Clinical audits were conducted to support the identification of potential risks to the quality of service provided. An example of this related to an audit of patient records regarding the vaccine for measles, mumps and rubella (MMR). The purpose was to check if this information had been entered correctly on the computer system and to identify any staff training needs in this area. As a result of this audit, the process for entering this data was changed to ensure any gaps in patients' records information could be clearly identified and the information sought. The practice had raised with the local Clinical Commissioning Group (CCG) potential risk where children's GP records were incomplete because immunisations had been given at school. This information was not routinely shared with GPs meaning immunisation records were incomplete. The practice had highlighted with the CCG the need for centralised data.

Risks were discussed at the monthly practice meeting and any action taken or necessary was documented and cascaded to all staff.

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 practice was responsive to the needs of older people. There was emphasis on continuity of care and arrangements to ensure those who were house-bound received sufficient care and support. Processes were in place to ensure over those aged 75 received regular health reviews.

Our findings

Older people we spoke with said they were very happy with the care and treatment they received. They said they were treated with dignity and respect and that the service met their healthcare needs. The service had a system for health reviews for those over 75. This check was done as and when patients attended or by recall. Staff were conscious of the particular needs of this group such as around mobility and hearing and planned their service accordingly. The building could easily be accessed by those with mobility problems and accessible toilets were available on the ground floor.

Integrated care team meetings took place every three months where those who would benefit from such a service were identified and planned for. This included those who were house-bound, at risk of isolation or who required extra support from community services. Older patients we spoke with said they were happy with the consistency of care as the clinical staff had remained the same for over 20 years.

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

The service was responsive to the needs of those with long term conditions. People with long term conditions such as diabetes, coronary heart disease (CHD) or osteoporosis were supported with annual, or when required health checks and medication reviews. Repeat prescriptions were limited to a three months' supply. Anti-depressants were prescribed for a maximum of one month at a time. This helped to ensure effective monitoring of patients on long term medication.

Our findings

During our inspection we saw the practice provided responsive, caring, effective and well led services for people with long term conditions. People we spoke with said they received sufficient support to manage their conditions and received regular check-ups.

Registers were maintained of patient with particular conditions so that they could receive the appropriate level of monitoring and review. Repeat prescriptions were limited to a three months' supply before a review had to take place. Anti-depressants were prescribed for a maximum of one month at a time. Patients told us dates for medication reviews were put on the prescription so they knew when they had to attend for this. This helped to ensure effective monitoring of patients on long term medication.

Appointments were planned in such a way as to allow extra time for those with long term conditions or more complex needs. This helped the practice ensure patients conditions were being properly managed and enabled them to identify and provide any further support that was required.

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, young children and young people. Processes were in place to ensure a full set of childhood vaccinations were offered and were properly recorded. The GPs were aware of the health related issues that affected young people and had measures in place to address these. Clinics were operated to address the particular health needs of this group.

Our findings

Mothers we spoke with said they were happy with the care and treatment they received. They said the service was responsive to their particular needs and the needs of their children.

The practice operated a baby/postnatal clinic weekly and a weekly well woman clinic. These clinics were set up exclusively to meet the needs of these groups. Babies were always seen the same day when appointments were required. Appointments were offered on a flexible basis in order to accommodate people's needs. An example was a family that was due to travel abroad during the school holiday. One child required a medication review. The GP decided this needed to be done before they travelled and therefore they were seen the same day. This demonstrated person-centred care with consideration of their individual needs.

One of the GPs explained how they offered young people advice about issues such as drug and alcohol misuse and sex education. This was done with sensitivity and consideration of parent's views and wishes. They explained how they tried to encourage parents to have open and honest discussions with young people about these issues to ensure they received correct information and advice.

The practice had developed some of its own clinical guidelines and protocols around childhood immunisations where good practice had been identified to ensure this was incorporated into people's care. The practice recorded the batch number, date of expiry, site of injection on the computerised records, in the child's Personal Child Health Record (Red Book) and the practice kept a written record. This practice was instituted to ensure immunisation information was readily available and up to date.

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 practice was responsive to the needs of working age people and those recently retired. The practice offered bookable appointments which included early mornings and late afternoons. Telephone consultations were also available and patients we spoke with had no problems contacting the practice by telephone.

Our findings

People we spoke with said the practice was accommodating and flexible with appointments. They were able to get appointments early in the morning or late afternoons. People were always able to get appointments easily when they needed them. Prescriptions could be sent directly to the local pharmacy so people did not have to attend the practice if this was inconvenient. Telephone consultations were also available if this was suitable.

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 practice was responsive to the needs of people in vulnerable circumstances. Annual health checks were carried out for patients with learning disabilities using a recognised tool.

Our findings

The practice had a number of patients registered who had a learning disability. We were told people within this group usually attended the practice with their carer. Staff were aware to ensure they communicated with the patient as well as the carer and to involve them in decisions about their care. Annual health checks were undertaken for patients with learning disabilities using a nationally recognised template. This helped to ensure the health checks were effective and that ensure care planning and delivery met their needs.

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 practice was conscious of the needs of people experiencing poor mental health. However their involvement with the local mental health team required improvement.

Our findings

The practice told us they did not have meetings with the local mental health team due to them having insufficient time. They said they had a single point of contact with mental health team who they found to be responsive. However they did not meet with them on a regular basis to discuss and review their patients. The practice told us social services was now closely merged with mental health services. They used this integration for patients by referral to the single point of contact. Improving contact and links with the mental health team would support more integrated care in order to ensure patients needs were met.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Patients were not protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for handling, safe keeping and safe administration of medicines used for the purposes of the regulated activity. This was because the process for checking medication was not sufficiently robust to protect people from the risk of receiving unsafe medication.