Moorfield Road Health Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Moorfield Road Health Centre is located in the London Borough of Enfield. The practice provides primary medical services to around 4,100 patients.

We carried out an announced inspection on 3 June 2014. The inspection took place over one day and was led by a lead inspector, a GP and a practice manager. An expert by experience was also part of the inspection team.

During our inspection we spoke with 13 patients who used the practice, and we received and reviewed four comments cards. We spoke with seven members of staff.

The regulated activities we inspected were diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease and disorder or injury.

Overall we saw that the service was responsive to the needs of older people, people with long term conditions, mothers, babies, children and young people, the working age populations and those recently retired, people in vulnerable circumstances and people experiencing poor mental health. People with long term conditions such as diabetes received regular reviews of their health condition at the practice.

The practice had systems in place to report and record safety incidents, concerns and near misses. However, measures were not in place to investigate, learn from these incidents and prevent them from happening again.

Safeguarding policies and procedures were in place and all staff had received training in safeguarding children and vulnerable adults. Staff were able to identify and respond to abuse appropriately.

Medicines for dealing with medical emergencies were held at the practice and staff had received training in Cardiopulmonary resuscitation (CPR). There were safe systems for the management of medicines, specifically controlled drugs which had been monitored and recorded in line with requirements. However, there were a number of medicines that were not accounted for and there was no stock record for them.

There was not a nominated lead for infection control at the practice. This had impacted on the cleanliness of the premises and clinical areas. The lack of infection control auditing also lead to insufficient cleaning procedures to continue.

There were formal processes in place for the recruitment of staff. However, these were not being followed. A disclosure and barring service (DBS) check (formally known as a criminal record bureau (CRB) check) had not been obtained for non clinical staff who acted as chaperones. Assessments had not been completed for those staff assessed as not in need of a check. This meant patients were not fully protected against the risks associated with the recruitment of staff.

The practice provided a caring, effective and responsive service. Patients' needs were suitably assessed and treatment was delivered in line with current legislation and best practice. GP's received an alert on their computer system when health checks were due. The practice arranged for people with long term conditions to attend for regular health care reviews on at least a six monthly basis. Health promotion and prevention took place through various health clinics held by the practice nurse. For example, patient's with diabetes automatically received regular blood checks and their weight monitored. There was good access to appointments. Home visits were undertaken according to patient's needs.

Patient's told us they felt cared for. Patients could speak to reception staff in private if required as the reception area did not provide a private environment. A hearing loop was available on the telephone system for people with hearing impairments. Although a telephone interpretation service was available which was regularly used by clinical staff, non clinical staff were not aware of it. They told patients to bring someone with them to interpret for them, which was not good practice.

The practice was not well-led on a day-to-day basis. It lacked leadership and a clear management structure. The provider did not have an effective system in place to analyse incidents or significant events that resulted in, or

had the potential to result in, harm of people using the service. There were no audit systems in place to assess and manage risks to the health and welfare of people who used the practice and others.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Safeguarding policies and procedures were in place for both children and vulnerable adults.

There were arrangements in place for the management of medicines. However, some medicines were not stored safely.

Patient's medical records were not always safely stored as they were accessible to those who were not authorised to do so.

Although the practice was open and transparent when there were incidents and recorded them as they occurred, action was not taken to improve systems and significant event audits were not completed to check improvement. This placed people who used the service at risk.

The practice did not have systems in place to ensure the right staffing level and skill-mix was sustained. Robust recruitment checks were not in place to ensure staff working at the practice were properly vetted to ensure the protection of people using the service.

There were not effective systems in place to reduce the risk and spread of infection. Clinical waste was not stored separately and was not stored in a separate yellow lockable bin.

Are services effective?

The clinical review system was not fully developed to ensure outcomes for patients were reviewed.

Patient's care and treatment was coordinated to meet their healthcare needs.

The practice provided a variety of health promotion information.

Are services caring?

The 13 patients we spoke to made positive comments about the way they were treated by the GPs and practice nurse and stated they found reception staff helpful.

Not all members of the reception team were aware of how to best communicate with patients who's first language was not English. Although clinical staff were using a telephone interpretation service regularly, reception staff were not aware of it and instructed patients to bring someone with them to their appointment.

Summary of findings

Patients told us they had been given adequate time for consultation with their GP, at each appointment they had attended. They told us that the clinician they had seen, or been treated by, had taken time to explain their diagnosis and proposed treatment.

Are services responsive to people's needs?

The practice understood the different needs of the population it served and implemented services to meet their needs. For example, specific clinics were operated to address the particular health needs of mothers and babies and various weekly clinics were operated to support those with long term conditions.

Patients were offered appointments at times suitable to them. The appointments system had been reviewed recently to ensure the practice was operating effectively. Where issues were found the appointment system had been amended and the number of appointments available each day had been increased.

There was a training programme in place for all staff but this did not provide training for staff to support them in their job role. For example, the current chaperone practice placed both staff and patients at risk. All staff including the GP's required further training in following best practice guidelines when acting as chaperones.

The GPs met regularly or at least every six months with the patient participation group (PPG). This was an opportunity to discuss any concerns about the quality of care. Members of the PPG we spoke with were complimentary about the practice and had no concerns or complaints.

There was a complaints policy available which detailed the complaints process and identified the relevant person who managed complaints and the time scales involved. All complaints were recorded and action had been taken to resolve the complaints.

Are services well-led?

The service was not well led. There was not a clear leadership and management structure, and areas of responsibility for each GP were unclear. Staff lacked clear sense of leadership.

The practice does not ensure that any risks to the delivery of high quality care were identified and mitigated before they adversely impacted on the quality of care.

The provider did not have an effective system in place to analyse incidents or significant events that resulted in, or had the potential to result in, harm of patients using the service. There were no audit systems in place to assess and manage risks to the health and welfare of people who used the surgery and others.

Summary of findings

Staff did have an annual appraisal to enable them to reflect on their own performance with the aim of learning and improving the service. Staff told us they felt very supported.	

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
Overall the service was responsive to the needs of older people.

Access to the surgery was via a ramped area. Hand rails were provided for support either side of any steps. The doors provided wide access for people in wheelchairs as treatment areas. We were told the practice team were all really helpful.

People with long-term conditions
Overall the service was responsive to people 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.

Mothers, babies, children and young people
Overall the service was responsive to mothers, babies, children and young people.

People with young children and babies we spoke with told us the service was quick to respond to appointment requests for young children and babies. Young children and babies were prioritised and given urgent appointments.

The working-age population and those recently retired
Overall the service was responsive to the working-age population and those recently retired.

The service offered bookable appointments which included early morning and late evening appointments. The practice offered a choose and book referral service when people needed to be referred to other services. Information on other services was also available.

People in vulnerable circumstances who may have poor access to primary care
Overall the service was responsive to people in vulnerable circumstances.

We were told the staff were very helpful and supportive. People we spoke with told us the GPs and practice nurse were approachable and happy to give help and advice. Homeless people were able to register with the practice.

Summary of findings

People experiencing poor mental health

Overall the service was responsive to people experiencing poor mental health.

The practice had close links with local community mental health teams as part of a multidisciplinary team. The practice kept in contact with the individual and offered regular health care reviews of their condition, treatment and medication.

Summary of findings

What people who use the service say

We spoke with 13 people who used the service during our inspection. We spoke with three representatives from the patient participation group (PPG). Patients told us they felt safe and had confidence in the GPs and nurse, and staff at the practice. They described the service provided as professional and felt they were well looked after. They told us they were involved in decisions about their care and treatment and were treated with dignity and respect.

Patient's did not raise any concerns about their safety. We looked at the completed four comments cards, which had been left at the service by CQC to enable people to record their views on the service. All the comments were positive and emphasised the standard and quality of care patients had received from the service. However, some patients were not satisfied with the number of appointments available.

Areas for improvement

Action the service MUST take to improve

- The provider must have effective systems in place to analyse incidents or significant events that resulted in, or had the potential to result in, harm of people using the service. Audit systems must be in place to assess and manage risks to the health and welfare of people who used the surgery and others.
- All staff including the GP's must receive required further training in following best practice guidelines when acting as chaperones.
- The national colour coded system for cleaning must be followed. The provider must ensure that maintenance of appropriate standards of cleanliness and hygiene on relation to the premises occupied for the purpose of carrying out the regulated activity were met.
- Robust recruitment checks must be completed to ensure staff working at the practice were properly vetted to ensure the protection of people using the service. Assessments had not been completed for those staff assessed as not in need of a check. This meant patients were not fully protected against the risks associated with the recruitment of staff.
- Patient's medical records were not all stored securely, which meant there was a possibility of unauthorised access.
- No stock records were maintained for medicines kept at the practice. Similarly no stock records were maintained in respect of vaccinations held. All medicines must be recorded and accounted for to ensure the safety of patients.

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Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Moorfield Road Health Centre

Moorfield Road Health Centre is a general practice (GP) service. It provides a primary care service for patients in Enfield. Services are provided by two full time GPs and a full time practice nurse. The service is responsible for providing primary care to around 4100 patients.

The practice was open from Monday to Friday.

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 provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We asked the practice to put comment cards where patients and members of the public could share their views and experiences of the service in reception.

Detailed findings

We carried out an announced visit on 3 June 2014. We spoke with 13 patients who used the service. We reviewed four comments cards where patients and members of the public and staff shared their views and experiences of the service.

During our visit we spoke with a range of staff which included two GPs, one practice nurse, one practice manager and three reception staff.

We looked at the practice's policies, procedures and some audits.

We reviewed information that had been provided to us during the visit and we requested additional information which was reviewed after the visit.

Are services safe?

Summary of findings

Safeguarding policies and procedures were in place for both children and vulnerable adults.

There were arrangements for the management of medicines. However, some medicines were not stored safely.

Patient's medical records were not always safely stored as they were accessible to those who were not authorised to do so.

Although the practice was open and transparent when there were incidents and recorded them as they occurred, action was not taken to improve systems and significant event audits were not completed to check improvement. This placed people who used the service at risk.

The practice did not have systems in place to ensure the right staffing level and skill-mix was sustained. Robust recruitment checks were not in place to ensure staff working at the practice were properly vetted to ensure the protection of people using the service.

There were not effective systems in place to reduce the risk and spread of infection. Clinical waste was not stored separately and was not stored in a separate yellow lockable bin.

Our findings

Safe Patient Care

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 within the practice and knew where to find the guidance. Any incidents and accidents were recorded in an accident book. Contact details for the Clinical Commissioning Group's (CCG) team were available, if required.

Learning from Incidents

Whilst incidents were reported, internal investigations were not always completed following significant events. For example, within the last two years six significant events had taken place and we found that in four of them no investigation or action had been taken to prevent reoccurrence. Two of these incidents related to medication. The first involved a prescription error and the second involved a repeat prescription being completed for the wrong person. We found follow up action had not been taken place to investigate the errors or to discuss the significant events.

Safeguarding

There was a safeguarding policy in place for the protection of vulnerable children and adults. This identified the forms of abuse and information on who to contact if they believed a child or adult was being abused. However, the policy did not include the contact numbers for the adults safeguarding team. The lead GP on safeguarding, the second GP partner and the practice nurse had all completed level 3 child protection training. We spoke to three members of the staff reception team and they all confirmed that they had received training in safeguarding which we saw certificates for. Staff were able to identify and respond to abuse appropriately.

The practice had a system to highlight vulnerable patients on their computerised records system. This information was available on their records when they contacted the practice or attended any appointments so that staff were aware of any issues.

Monitoring Safety & Responding to Risk

The practice had systems and protocols in place to ensure business continuity in the event of any emergency, for example, power failure or flood. The practice manager informed us that they had a power cut last year. As a result

they requested a generator for the building from the local Clinical Commissioning Group (CCG) which would supply electrical power if there was a further power cut, but this had not yet been supplied. The contingency plan in place identified all the emergency contact numbers for other local practices the practice had a mutual agreement with if they were unable to use their own premises. The plan also included contact numbers for all medical and vaccination suppliers. This ensured patients continued to receive a healthcare service in the event of an emergency.

The practice did not have systems in place to ensure the right staffing level and skill-mix was sustained at all hours, to ensure the service was open to support safe, effective and compassionate care and levels of staff well-being. We were told locum GP's would be employed to cover sickness or annual leave periods but there were no contingency plans in place to identify how the service would cope and provide cover if the practice nurse was not available. This did not ensure there were enough suitably skilled staff to enable the continuity of a safe service. Staffing levels were not reviewed at practice meetings or during a yearly organisational audit.

Regular reviews of health and safety took place. A health and safety risk assessment was completed annually and fire drills took place regularly. A fire evacuation plan and the meeting point were displayed in the reception area for patients to see.

Patient's paper medical records were stored in the reception office which patients in the waiting area could have unauthorised access. This was because the door to the office was kept open during surgery hours. We discussed this with the practice manager who informed us they were aware that a safety secure coding system needed to be fitted to the door, which would only allow staff access to the room. However, this had not been documented or communicated to the property maintenance company responsible for the building. This meant patient's records were not always safely stored.

Medicines Management

Vaccine fridges were locked and their temperatures were monitored daily and logged. The practice nurse ordered the vaccines and had a system in place to identify any out of date vaccines. We checked medicines within the fridges and found them to be in date. We were told by the GPs they did not carry any drugs with them or on home visits.

We found a number of medications which there was no stock record for. We also did not see stock lists for all the vaccinations held. All medications must be recorded and accounted for to ensure the safety of people using the service.

Cleanliness & Infection Control

Effective systems were not in place to reduce the risk and spread of infection. We were told that external contractors cleaned the practice on a daily basis. We saw daily cleaning schedules and looked at the storage for all cleaning equipment. They used a national colour coded system to ensure different cleaning equipment was used for the kitchen, administrative areas and sanitary areas, for example toilets. The colour coded system was not being followed as we saw colour coded mops were not being used with their corresponding buckets. In addition, there was dust on the nurse's couch, which had not been cleaned. There was not an infection control lead and regular audits had not taken place of the cleaning processes in place.

Clinical and non clinical waste was stored outside the main building. Sharps bins were sealed and labelled. However, the waste area was full and both types of waste, clinical and non clinical were stored together. The practice manager could not tell us when the waste was last collected. Clinical waste must be stored separately and should be stored in a separate yellow lockable bin.

The consultation rooms had sinks, liquid soap and paper towels available. Disposable privacy curtains were used and there was a clear system to ensure they were changed at appropriate intervals. Clinical areas were not carpeted and had easy wipe clean vinyl flooring.

Staffing & Recruitment

There were insufficient recruitment checks in place to ensure staff working at the practice were properly vetted to ensure the protection of patients using the service. The practice manager had recently implemented a recruitment policy for recruiting staff to work at the practice. The recruitment policy in place identified all the checks new employees would have to undergo before they could be considered for employment. No new employees had been recruited since the introduction of the policy.

3 recruitment files for non clinical staff were examined and all 3 did not have a completed application form. One file did not have evidence of a work permit as the member of

Are services safe?

staff was not a British citizen. Two of these staff members acted as chaperones but did not have an enhanced disclosure and barring service (DBS) check to ensure their suitability to work with vulnerable people.

Dealing with Emergencies

There were appropriate emergency medications and medical equipment available at the practice, which were checked monthly. We checked medication for emergency use and found all medication was in date. Staff had received training in Cardiopulmonary resuscitation (CPR).

Equipment

There was not a defibrillator (a defibrillator is an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart), but there was an oxygen cylinder on the premises which was checked to ensure it was working and was full on a monthly basis by the practice nurse. Staff were unaware of where the nearest defibrillator was located. This did not ensure that all emergency equipment was available for use in a medical emergency. We discussed this with the provider, at the time of our inspection, and they agreed to take immediate action to resolve the issues.

Are services effective?

(for example, treatment is effective)

Summary of findings

The clinical review system was not fully developed to ensure outcomes for patients were reviewed.

Patient's care and treatment was coordinated to meet their healthcare needs.

The practice provided a variety of health promotion information.

Our findings

Promoting Best Practice

Best practice was promoted by both GPs and the practice nurse. All three clinicians informed us they received safety alerts through their email system. The practice nurse told us all clinical alerts followed National Institute for Health Care and Excellence (NICE) guidelines and were flagged up in her inbox. We saw alerts for people that required chronic obstructive pulmonary disease, diabetic and asthma checks. People were then contacted by reception staff to arrange an appointment for their check-up.

Internal audits were completed to ensure patients with long term conditions were reviewed. For example, patients identified with dementia were seen regularly by the GPs and were highlighted on the computerised system when checks were due. The practice nurse offered smoking cessation advice and had completed her level two training course to enable her to deliver this advice. She told us she also referred patients to an external team for further support.

Management, monitoring and improving outcomes for people

The clinical review system had not been fully developed to ensure outcomes for patients were always reviewed. Moorfield Health Centre in comparison to the national average had a low percentage rate for the early detection of cancer. Although the GPs were aware that there was a need to audit their detection of cancer rates, they informed us this had not yet taken place.

An audit had been completed by one of the GPs which looked at the practice's Accident and Emergency (A & E) attendance. As a result of the high number of people attending A & E, telephone consultations had been introduced. However, no other action had been to taken to look at ways of reducing this, for example by looking at the current appointment system and rate of appointments offered.

Staffing

Staff received appropriate professional development. We looked at the files for five members of the non-clinical staff team and found that they had all received annual appraisals. The practice nurse was appraised by one of the

Are services effective?

(for example, treatment is effective)

partner GP's and we saw documented evidence of both GP appraisals being completed by an external appraiser. The practice nurse told us she felt supported to maintain her professional development and attend training courses.

Working with other services

There was documented evidence of multi- disciplinary meetings taking place, but they did not take place on a regular basis. We saw four meetings had taken place with other health professionals' to discuss the treatment of patients over the last year. The provider may like to note that a structured and a more systematic approach was required for holding meetings with other professionals. These meetings were not planned in advance. We saw that all people with long term care needs, for example dementia and those who required palliative care needs and end of life care were reviewed during these meetings.

We found that information about patients who had contacted the out of hours service were reviewed by a GP at the practice. All clinical post was scanned onto the computer system by staff and was action by the GP was taken within a week.

Health Promotion & Prevention

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable people, making a compliant, alcohol abuse support, pregnancy, cancer care, managing cholesterol, bereavement services, sexual health and other long term conditions.

All new patients received a new patient check by the practice nurse. If health concerns were identified then they were seen by one of the GPs. The practice nurse informed us of health promotion within the practice and talked about patients with a diagnosis of diabetes. She informed us they would automatically receive regular blood checks and have their weight monitored. They would be advised about implementing lifestyle measures to manage their condition through diet and exercise.

A weekly baby clinic was held by the practice nurse. The practice nurse told us that during this clinic as well as providing immunisations to children she also promoted breast feeding and well women checks with the mothers. She told us she worked closely with the health visitor and midwife to provide a coordinated service.

Sexual health screening was actively promoted at the practice and information leaflets on contraception were provided in the waiting area. The practice nurse told us she gave new mothers contraception advice.

As part of health promotion, smear clinics were held by the practice nurse to encourage female patients to undertake well woman checks. Information leaflets on the importance of smears were given to women and were displayed in the waiting area. We saw evidence of audits to evidence when people were recalled for their checks. An audit was also kept of all inadequate samples to ensure women were called back in to retake their test.

Are services caring?

Summary of findings

The 13 patients we spoke to made positive comments about the way they were treated by the GPs and practice nurse and stated they found reception staff helpful.

Not all members of the reception team were aware of how to best communicate with patients who's first language was not English. Although clinical staff were using a telephone interpretation service regularly, reception staff were not aware of it and instructed patients to bring someone with them to their appointment.

Patients told us they had been given adequate time for consultation with their GP, at each appointment they had attended. They told us that the clinician they had seen, or been treated by, had taken time to explain their diagnosis and proposed treatment.

Our findings

Respect, Dignity, Compassion & Empathy

We spoke with 13 patients who used the practice and received feedback from four patient participation representatives. They told us they had a good relationship with the practice and the GPs and the practice nurse listened to their views and took these into account when offering treatment.

The reception area was situated within the waiting area and did not always provide a private environment. However, private office space was available for patients to speak confidentially to clinical and non-clinical staff members. Staff rooms were also available for staff to speak privately with patients over the telephone.

Consultations took place in private. There were signs explaining that patients could ask for a chaperone during examinations if they wanted one.

Involvement in decisions and consent

Patients told us they had been given adequate time for their consultation with their GP, at each appointment they had attended. They told us that the clinician they had seen, or had been treated by, had taken time to explain their diagnosis and proposed treatment.

A hearing loop was available on the telephone system for patients with hearing impairments. A telephone interpretation service was available for staff to use with patients who did not speak English. The practice nurse told us she had used this on a regular basis. However, not all reception staff were aware of the service and told us they told patients to bring someone with them to their appointment as no interpreters were offered by the practice. This was not good practice.

Patients who used the service said they were involved in planning their care and were supported to make their own decisions. Time was taken to explain their diagnosis and treatment and they felt able to ask questions and express their own opinions. The practice nurse told us how she ensured patients with learning disabilities and their families were involved during treatment and that they always obtained informed consent from their families and representatives. She told us that she always sought parental advice and consent before babies and children were immunised to ensure they received treatments parents had consented to.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice understood the different needs of the population it served and implemented services to meet their needs. For example, specific clinics were operated to address the particular health needs of mothers and babies and various weekly clinics were operated to support those with long term conditions.

Patients were offered appointments at times suitable to them. The appointments system had been reviewed recently to ensure the practice was operating effectively. Where issues were found the appointment system had been amended and the number of appointments available each day had been increased.

There was a training programme in place for all staff but this did not provide training for staff to support them in their job role. For example, the current chaperone practice placed both staff and patients at risk. All staff including the GP's required further training in following best practice guidelines when acting as chaperones.

The GPs met regularly or at least every six months with the patient participation group (PPG). This was an opportunity to discuss any concerns about the quality of care. Members of the PPG we spoke with were complimentary about the practice and had no concerns or complaints.

There was a complaints policy available which detailed the complaints process and identified the relevant person who managed complaints and the time scales involved. All complaints were recorded and action had been taken to resolve the complaints.

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and implemented services to meet their needs. For example, services had been planned and designed to meet the needs of older patients as there was a high proportion of older people on the patient list. There was a system for health reviews for those over 75 and those with long term conditions. This check was done as and when patients attended or by recall. Clinical staff were conscious of the particular 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. Specific clinics were operated to address the particular health needs of mothers and babies.

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.

There was a programme of mandatory training in place for all staff but this did not provide all staff with the specific skills required for their role. For example, we found reception staff were acting as chaperones without having received any training or a DBS check. The practice policy stated 'Where the practice determines that non-clinical staff will act in this capacity, the patient must agree to the presence of a non-clinician in the examination, and be at ease with this. The staff member should be trained.' We observed a member of the reception team called to act as a chaperone. On their return they told us they do not witness the actual examination taking place and sit in the room while the curtain is drawn. They told us they were aware their was a chaperone policy but had not read it. To ensure the protection of the patient and staff, a chaperone must be a witness to the procedure directly. The current chaperone practice placed both staff and patients who use the service at risk. All staff including the GP's required further training in following best practice guidelines when acting as chaperones.

Are services responsive to people's needs?

(for example, to feedback?)

Administration systems were in place to ensure referral letters were sent out in a timely manner. Patients were contacted by telephone to arrange appointments with the GP if blood results had to be discussed. Where patients were discharged from hospital the practice received hospital discharge information by electronic links which the reception team received and dealt with.

Patients with mental health conditions were offered regular check ups and the practice nurse informed us they referred and liaised with the community psychiatric nurse who they had strong links with.

The premises met the needs of patients who may have mobility needs. There was ground floor access to the practice and a lift was available and was maintained annually. The entrance, reception area and consulting rooms were big enough for people with pushchairs and wheelchairs. There was also a toilet for disabled people. We found there were accessible parking spaces available on the car park outside the main entrance.

Access to the service

The practice opened from 8.30am to 12 noon Monday to Friday. They closed from 12 to 2.30pm. During the closure, staff took telephone calls for appointments and GP's completed home visits and carried out telephone consultations. The practice opened to patients to see clinical staff again at 2.30pm to 6.30pm from Wednesday to Friday. They also offered two late night openings on Monday and Tuesday. From the 13 we spoke with and the four comment cards we received, one person on their comment card informed us they were not always able to get an appointment. Another person we spoke to told us they had to wait two weeks to see their GP which they thought was too long. We also saw recorded documentation of a complainant who had raised concerns with the practice manager about not being able to get an appointment. On examining the appointment system we found that extra and emergency appointments were added when needed. However, some patients were not satisfied with the number of appointments available.

Concerns & Complaints

The GPs met regularly or at least every six months with the Patient Participation Group (PPG). This was an opportunity to discuss any concerns about the quality of care. The four members of the PPG we spoke with were complimentary about the practice and had no concerns or complaints. The practice had received three complaints from patients who used the service within the last year. They had been recorded in detail and the complainants had been responded to by the practice manager who had recorded the action they had taken to resolve the complaints. 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 any complaints in writing.

Are services well-led?

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

Summary of findings

The service was not well led. There was not a clear leadership and management structure, and areas of responsibility for each GP were unclear. Staff lacked clear sense of leadership.

The practice does not ensure that any risks to the delivery of high quality care were identified and mitigated before they adversely impacted on the quality of care.

The provider did not have an effective system in place to analyse incidents or significant events that resulted in, or had the potential to result in, harm of patients using the service. There were no audit systems in place to assess and manage risks to the health and welfare of people who used the surgery and others.

Staff did have an annual appraisal to enable them to reflect on their own performance with the aim of learning and improving the service. Staff told us they felt very supported.

Our findings

Leadership & Culture

We did not find clear leadership within the practice. The practice manager told us they did not have a business plan in place or a vision for the future. On speaking to reception staff we found they lacked a clear sense of direction and leadership. One of the partner GPs told us they would be looking at retirement in the next two to three years and did not know of any succession planning. Both GPs recognised the importance of maintaining high standards and were conscious people could leave the practice if they were dissatisfied.

We were informed by the practice manager that they did not have systems in place to assess the skill mix of staff and staff shortages would be dealt with by internal locum cover for reception and clinical staff. This did not identify whether the current staffing levels were suitable in meeting the demands of patients using the service and whether their skills and training were appropriate for their job role.

Governance Arrangements

The practice manager was responsible for governance, but no audits had been undertaken in relation to the running of the practice, for example fire safety, health and safety, staffing or the demands on the service. They told us they had completed a recent audit regarding the capacity of appointments. No audits had been completed for infection control or of clinical systems.

A system was in place to review staff training. Clinical staff received appropriate professional development and training. We saw evidence of regular training and course attendance supported by certificates. The courses attended included: basic life support, cardio pulmonary resuscitation (CPR), infection control and safeguarding adults and children.

Systems to monitor and improve quality & improvement

The practice did not ensure that any risks to the delivery of high quality care were identified and mitigated before they adversely impacted on the quality of care. Risks were not discussed at regular meetings as these only took place after a significant event had occurred. Any action taken or necessary was not documented and shared with all staff.

Are services well-led?

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

Patient Experience & Involvement

The practice had not undertaken an internal patient survey and the only survey was completed by NHS England. There was a 39 per cent completion rate and 92 per cent of respondents said they had confidence and trust in the last GP they saw or spoke to. The Patient Participation Group included eight members. We spoke to three members and they were very complimentary about the practice and told us that they were always able to get an appointment with their own doctor. The GPs met with the PPG every six months and any planned changes were discussed with the group.

Staff engagement & Involvement

Three members of reception staff told us they felt supported and listened to. Staff said they were encouraged to put forward their own ideas about how to improve the service. However, regular staff meetings did not take place where they could discuss any areas for improvement that had been identified and ensure they were addressed.

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. We looked at three staff member's files and the records we saw supported this. However, we found that areas of concern were not always monitored by the practice manager to assess whether aims and objectives discussed during appraisal meetings were being achieved competently.

There was an awareness by the clinical team to learn from feedback and significant events however, formal systems were not in place to ensure that significant event review meetings took place on a regular basis. The lack of these systems impacted on the running of the practice and did not encourage it to improve its practices.

There was an emphasis on management and the clinical staff seeking to learn from stakeholders, in particular through the local CCG and the patient participation group.

Identification & Management of Risk

There were checks of the safe running of the practice such as legionella testing, testing of electrical equipment, building security systems, the lift at the premises and the automatic door system. We saw the practice manager was aware of the poor state of the premises. We saw furniture in the nurses room such as the patient couch, storage cupboard for equipment were broken. We saw written correspondence to the building maintenance company, demonstrating the practice was aware and trying to take action in response to these issues.

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

Overall the service was responsive to the needs of older people. Access to the surgery was via a ramped area. Hand rails were provided for support either side of any steps. The doors provided wide access for patients in wheelchairs as did the reception and treatment areas.

Our findings

During our inspection we saw the practice provided responsive, caring, effective and well led services for older people. Patients told us they were happy with the service provided and felt the GPs, the nurse and staff were caring and treated them with respect. People told us that in times of bereavement the practice had been very supportive and offered access to other services such as counselling. There were systems in place to recognise people's carers and their needs. There were monthly multidisciplinary meetings with the clinical staff which included local District Nurses and McMillan nurses. These meetings gave the practice the opportunity to discuss and review people's care needs. We were told people were supported to make informed decisions about their treatment and they were happy with the care the practice offered to them. There was a named GP for those over 75 years of age.

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

Overall the service was responsive to patients with long-term conditions.

Our findings

The practice provided responsive, caring, effective and well led services for people with long term conditions. Patients with long term conditions such as diabetes, coronary heart disease (CHD) or asthma were supported with annual, or when required, health checks and medication reviews. They told us that they were happy with the care and treatment they received and felt they were involved in decisions about their care and treatment.

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

Overall the service was responsive to mothers, babies, children and young people. The service provided appointments for teenagers who request confidential advice on contraception and sexual health.

Our findings

During our inspection we saw the practice provided responsive, caring, effective and well led services for mothers, babies, children and young people. There was access to the community midwifery services. Patients we spoke with told us the practice was very supportive and prioritised urgent appointments for young children and babies.

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

Overall the service was responsive to the working-age population and those recently retired.

Our findings

The practice provided responsive, caring, effective and well led services for working age people (and those recently retired.) The service offered bookable appointments which included early morning and late evening appointments. The GP practice manager audited the appointments system to ensure any shortfalls in staff or appointment availability were responded to in a timely manner. The practice offered a choose and book referral service when patients needed to be referred to other services. Information on other services was also available.

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

Overall the service was responsive to people in vulnerable circumstances.

Our findings

Patients we spoke with told us the doctors and nurses were approachable and happy to give help and advice. We told homeless people would be registered at the practice.

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

Overall the service was responsive to people experiencing poor mental health. The practice liaised with local community mental health teams and clinical psychologists as part of a multidisciplinary team. The practice liaised with the individual and offered regular health care reviews of their condition, treatment and medication.

Our findings

The practice provided responsive, caring, effective and well led services to patients who may be experiencing poor mental health. Patients with on-going mental health conditions were invited for annual health checks. These checks included other health checks , for example cervical smears, blood pressure checks and smoking cessation advise. The practice offered a reminder service to patients to promote attendance at health care reviews and medication reviews. Patients who did not attend were contacted by the practice nurse immediately, normally by telephone, and an attempt would be made to encourage them to attend the review. The practice liaised closely with other health services, for example the community mental health team.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. The provider did not have an effective system in place to analyse incidents or significant events that resulted in, or had the potential to result in, harm of people using the service. There were no audit systems in place to assess and manage risks to the health and welfare of people who used the surgery and others. Regulation 10 (1), (b), (c), (i).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers All staff including the GP's required further training in following best practice guidelines when acting as chaperones. Regulation (1),(a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. The practice did not ensure that maintenance of appropriate standards of cleanliness and hygiene on relation to the premises occupied for the purpose of carrying out the regulated activity were met. Regulation 12 (2), (c), (i).

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers. Robust recruitment checks were not in place to ensure staff working at the practice were properly vetted to ensure the protection of people using the service. Regulation 21 (a),(i), (ii), (b).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records. Patient's medical records were not all stored securely, which meant there was a possibility of unauthorised access. Regulation 20 (2),(a).

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines. Medicines were not stored safely, which there was no stock record for. We also did not see stock lists for all the vaccinations held. All medications must be recorded and accounted for to ensure the safety of patients using the service. Regulation 13 (1).