Curzon Avenue Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Curzon Avenue Surgery is in Ponder's End in the London borough of Enfield. The practice provides primary medical services and level 1 minor surgery (joint injections) to approximately 5,900 patients and is situated in a converted residential premises. Curzon Avenue Surgery is a training practice for GP registrars. These are qualified doctors who wish to pursue a career in general practice.

During our inspection we spoke with clinical and non-clinical staff at the practice and patients who used the practice. We also spoke to members of the Patient Participation Group (PPG).

We found the service was responsive to the needs of older patients, patients with long-term conditions, mothers, babies, children and young people, working age populations and those recently retired, patients in vulnerable circumstances and those experiencing poor mental health. Patients with long-term conditions, such as diabetes, received regular reviews of their health conditions.

The practice informed patients about the services it provided, although information was not routinely available in other languages, for example Turkish, to cater for the needs of the large Turkish population. The practice encouraged patients experiencing poor mental health to attend for regular reviews and liaised with the local drug and alcohol teams and voluntary services. There was good access to appointments, which were prioritised according to risk. GPs made home visits and operated a telephone service at the start and end of the day to cater for patients who worked and were unable to attend the practice during normal hours.

We found there were some areas where the practice could make improvements to services. For example, the practice nurse attending weekly practice meetings with clinical staff and taking the lead on health promotion. The current practice arrangements make it difficult for non-clinical staff to meet on a regular formalised basis. The practice would benefit from a more robust prescription tracking system.

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 service was safe but some aspects required improvement. The practice took some action at the time of our inspection, including obtaining a larger capacity bin to store clinical waste and carrying out a fire risk assessment.

The practice had systems in place to safeguard vulnerable patients from the risk of harm. These were in place for both children and vulnerable adults, which enabled staff to both recognise and act appropriately on concerns in relation to abuse.

Patients were protected from the risks associated with medicines because there were effective systems in place to store and monitor medication.

Systems were in place to ensure that infection control was monitored and reviewed so that patients were protected against the risk of contracting health-care associated infections.

The practice had appropriate arrangements in place to deal with emergencies and learned from incidents and complaints.

Are services effective?

The practice provided effective care for patients.

Arrangements were in place to monitor and improve patient health outcomes by discussing any issues at practice clinical meetings and multi-disciplinary meetings. Clinicians were able to prioritise patients according to need and were able to make use of available resources.

We reviewed prescribing at the practice. Staff were appropriately qualified and had opportunities to develop their skills and knowledge base.

We found the practice engaged and worked in partnership with other services to meet patient's needs in a coordinated and effective manner, including reviewing the information received from out-of-hours services.

The practice provided a variety of health promotion information for patients, such as smoking cessation, diet and healthy living.

Are services caring?

Patients received services that were caring.

Summary of findings

Patients felt their views were taken into account and that they were treated with dignity and respect. They told us they were involved in decisions about their care and that staff, both clinical and non-clinical, were approachable and listened.

The GP patient survey undertaken in 2014 showed patients felt the GPs and nurse at the practice treated them with care and respect. We saw that where patients did not have the capacity to consent, the practice would act in accordance with legal requirements. Comments on NHS Choices were also largely positive about the caring attitude of staff.

Are services responsive to people's needs?

The practice provided a responsive service.

We found that the practice took time to understand the individual needs of patients and made reasonable adjustments where necessary. The service had good arrangements in place to ensure that it could meet patients' needs in a timely fashion.

The practice acted on complaints and concerns from patients and used this to inform improvements to service provision.

Are services well-led?

The service was well-led.

There was a clear leadership and management structure across the partnership and areas of responsibility were defined. The partners and practice manager we spoke with understood how they needed to take forward the practice to improve patient experiences. The major limiting factor to the practice was the size of the premises, and partners were engaged in the early stages of discussion with the local Clinical Commissioning Group CCG how it might be increased. The practice had begun to develop a formal business plan to support this and its goal of providing good continuity of care. This process was expected to take up to five years.

We saw that staff had an annual appraisal to enable them to reflect on their own performance, with the aim of learning and continuous improvement. Staff we spoke with felt supported. There was evidence of a range of meetings.

There was a commitment to learn from complaints, feedback and incidents. Management put an emphasis on learning from stakeholders, in particular the local CCG, Patient Reference Group (PRG) and the recently formed Patient Participation Group (PPG).

Summary of findings

The six population groups and what we found

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

Older people
The service was responsive to the needs of older patients.

Older patients we spoke with and some of the comment cards we received demonstrated that patients were cared for with dignity and respect and were happy with the care received.

The practice worked with other healthcare professionals and community services to ensure older patients received appropriate assessment, planning and delivery of care.

The practice offered health checks and health promotion to patients in this population group. Staff we spoke with demonstrated an awareness of involving older patients and their family or carer in making decisions about their care and treatment.

People with long-term conditions
The service was responsive to patients with long-term conditions.

Patients with long-term conditions such as diabetes, coronary heart disease (CHD) or osteoporosis were supported with annual or as required health checks and medication reviews. The four partners at the practice operated their own patient lists and had a good knowledge of their patients' needs.

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

Patients told us that the practice was quick to respond to appointment requests for young children and babies.

The service provided appointments for teenage patients who requested confidential advice on contraception and sexual health.

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

The practice offered bookable appointments, which included early mornings and late evenings three times a week. GPs also offered telephone advice and directed patients to appropriate appointments as required.

The practice manager and GP partners audited the appointments system and staff availability to ensure that any shortfalls in staff or

Summary of findings

appointment availability were quickly addressed. For example, extra staff had been moved to later evening shifts recently to cope with extra demand. Information on other health services was also available.	
People in vulnerable circumstances who may have poor access to primary care The service was responsive to patients in vulnerable circumstances. Patients we spoke with told us that both the doctors and nursing staff were very helpful and supportive. There was access to drug and alcohol recovery services via the practice and signposting to other voluntary support services.	
People experiencing poor mental health The service was responsive to patients experiencing poor mental health. The practice liaised with community mental health teams and clinical psychologists as part of a multi-disciplinary team. The practice liaised with patients and offered regular reviews of their condition, treatment and medications.	

Summary of findings

What people who use the service say

During our inspection we spoke with seven patients who used the service, including representatives from the Patient Participation Group (PPG). We also spoke to people at a drop-in session for patients who wished to speak to the inspection team. Patients told us they felt safe and confident in the GPs, nursing staff and receptionists at the practice.

Patients described the service in positive terms, especially the care and treatment offered by named doctors. Patients felt listened to; clinicians explained treatment to them and they felt they had been treated with dignity and respect. Patients' confidentiality was maintained. They said the practice was clean and tidy when they attended their appointments and had no specific concerns.

Patients told us they felt safe coming to the surgery. Before our inspection we provided comment cards at the practice for patients to fill in and put in a sealed container. These gave patients the opportunity to give their views on and experiences of the service. Of the 16 completed cards, all the comments were positive, expressing praise for the care people had received at the practice.

Areas for improvement

Action the service COULD take to improve

- Weekly practice meetings, to share information on patient care, were being currently held on a day that the practice nurse was not able to attend.
- Health promotion was led by GPs. It was recognised that greater involvement from nursing staff would lead to improvements as the practice grows.
- Arrangements at the practice made it difficult for non-clinical staff to have regular formal meetings.
- The tracking system for prescriptions tracking system did not log serial numbers on receipt or track distribution to clinical staff.

Good practice

Our inspection team highlighted the following areas of good practice:

There was an open learning culture at the practice and a passion around continuity of care with patients seeing a named GP.

Curzon Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP. The team also included a practice manager.

Background to Curzon Avenue Surgery

Curzon Avenue Surgery is in Ponder's End in the London borough of Enfield. The practice provides primary medical services to approximately 5,900 patients and is situated in a converted residential premises. It is operated by four GP partners, a practice manager, one practice nurse and a team of reception and support staff. Curzon Avenue Surgery is a training practice for GP registrars. During our inspection the practice had two GP registrars working as part of its practice team. It had good relationships with other local practices, care homes and supported living services, and community drug and alcohol recovery teams.

The practice recognised that the main limiting factor it had to contend with was the relatively small size of its premises. It was engaged with the local CCG and other partners to determine whether alternative larger local premises might become available. The surgery was open from 8am to 6.30pm Monday to Friday, with extended opening hours until 7pm on Tuesday, Wednesday and Thursday evenings. After normal practice hours, BARNDOC (a cooperative of local GPs) provided out-of-hours cover from 6.30pm to 8am Monday to Friday and at weekends and bank holidays.

The area has a diverse urban population within an area of higher than average deprivation and a higher than average younger population.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- 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 such as NHS England, and the local Healthwatch and Clinical Commissioning Group (CCG), to share what they knew

Detailed findings

about the service. We asked the practice to put our comment cards in reception where patients and members of the public could share their views and experiences of the service.

We carried out an announced visit on 4 June 2014. During our visit we spoke with seven members of staff ranging from partner GPs, the practice nurse and practice manager to reception staff, and we spoke with seven patients, including members of the Patient Participation Group (PPG) who used the service. We reviewed 16 comment cards that had been left in a sealed container in the reception area.

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 we reviewed after the visit.

Are services safe?

Summary of findings

The service was safe, but some aspects required improvement. The practice took some action at the time of our inspection, including obtaining a larger capacity bin to store clinical waste and carrying out a fire risk assessment.

The practice had systems in place to safeguard vulnerable patients from the risk of harm. These were in place for both children and vulnerable adults, which enabled staff to both recognise and act appropriately on concerns in relation to abuse.

Patients were protected from the risks associated with medicines because there were effective systems in place to store and monitor medication.

Systems were in place to ensure that infection control was monitored and reviewed so that patients were protected against the risk of contracting health-care associated infections.

The practice had appropriate arrangements in place to deal with emergencies and learned from incidents and complaints.

Our findings

Safe patient care

The practice had systems in place to report and record safety incidents, complaints and safeguarding concerns, which ensured the safety of patients. Staff, both clinical and non-clinical, showed an awareness of their role in reporting concerns. We saw that any lessons learnt were shared with staff during meetings.

Learning from incidents

The practice was open and transparent when there were near misses or when things went wrong. There was a policy in place to enable staff to recognise and act on significant events or incidents. We reviewed the 12 significant events that had occurred at the service over the last 12 months. We saw that they had been documented and discussed, and learning and actions had been identified and shared at practice meetings. The practice had recently identified a significant event. We saw that the investigation had identified some learning points relating to referrals and prescriptions and, as a result, the practice had changed it's referral and prescription processes.

Safeguarding

The practice had policies and protocols in place for adult and child safeguarding. GPs were trained to level 3 and the practice nurse to level 2. Non-clinical staff had also received safeguarding training. There was a lead GP nominated by the practice who told us that they liaised closely with the local safeguarding team.

Staff we spoke with had a satisfactory understanding of safeguarding procedures and knew what action to take. They said they would speak to either the practice manager or lead GP if they had concerns. The practice had a flagging system on their computerised records that indicated vulnerable patients so that staff were aware of any issues.

All the patients we spoke with told us they felt safe visiting the practice and they were happy with the care and treatment they received. There was a chaperone policy in place which was clearly publicised in the reception area and on entry to each of the four consultation rooms.

Monitoring safety and responding to risk

The practice had business continuity systems in place for use in the event of an emergency, for example, a power failure or flooding of the premises.

Are services safe?

Arrangements to respond to changes in demand at the practice were discussed at weekly practice meetings. Approval had recently been given for more staff to work later in the evenings to match an increased demand and ensure continuity of care.

We saw there were health and safety risk assessments but no current fire safety risk assessment. We spoke with the practice manager who said this would be actioned immediately. We saw evidence of fire drills at the practice.

Medicines management

We looked at the storage and monitoring of medicines to ensure that they were in date and correctly managed. This included emergency medicines and vaccines. We saw that there were appropriate systems in place for obtaining, recording, handling, storing and using medicines. Medicines were mostly stored correctly; however, we did find a small quantity of medicines that had been left in a cupboard in a storage room awaiting disposal. These were not controlled drugs. When pointed out to the practice manager, arrangements were made immediately with a local pharmacist for the medicines to be returned.

The vaccine fridge was kept locked. We saw that refrigerator temperatures were monitored daily, to ensure they remained between two and eight degrees Celsius, and that the vaccines were in date. We were told by the GPs that they did not carry any drugs with them on home visits.

We noted that the current prescriptions tracking system did not log serial numbers on receipt or track distribution to clinical staff. The practice would benefit from a more robust prescription tracking system.

Cleanliness and infection control

Patients we spoke with told us they found the premises to be clean. We found the practice to be visibly clean and tidy. We were told that the practice had recently appointed a new cleaning contractor. There were cleaning schedules that gave details of the activities to be completed. However, we noted that mops and buckets were not appropriately stored and had been placed in a rear office where a member of staff was working. We discussed this with the practice manager who agreed to take immediate action to find more appropriate storage.

Consultation and treatment rooms had access to sinks, paper towels and hand gel. Disposable privacy blinds were used and we saw there was a system to ensure they were replaced at regular intervals. Sharps bins were not more than two thirds full and were labelled to denote when and by whom they had been assembled. A contract was in place to remove clinical waste on a regular basis and a locked external storage bin was in place at the front of the premises. The practice's infection control policy contained written guidance for staff reference and staff we spoke with understood their responsibilities in relation to this. We did note that the current storage bin for clinical waste was too small, and before we left the practice a new, larger, bin had been ordered with interim safety arrangements in place to prevent over-filling.

Staffing and recruitment

The provider had a process in place for recruiting staff who worked at the practice. Checks were undertaken of GPs and nurses to ensure their fitness to practice, for example checking their General Medical Council registration. These were recorded when clinicians joined the practice. Enhanced disclosure and barring (DBS) checks were undertaken for clinical staff to ensure their suitability to work with vulnerable people. These checks were also undertaken for GP registrars.

Dealing with Emergencies

Processes were in place for dealing with emergencies that were likely to affect services. Emergency medicines and medical equipment were available at the practice for emergency use and staff knew of their location. Medicines had been checked and were in date and subject to regular review. Systems were in place to store medicines allowing immediate access in emergency situations. The practice had formal "buddy" arrangements with two other local practices in case of emergency including IT failure and to preserve the temperature of stored vaccines.

Equipment

There were suitable arrangements in place to ensure equipment was properly maintained and fit for purpose. There was 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), and an oxygen cylinder. These were in date and subject to servicing by an external contractor. The practice also had a nebuliser to assist people with breathing difficulties. Equipment was checked annually and recalibrated as necessary.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice provided effective care for patients.

Arrangements were in place to monitor and improve patient health outcomes by discussing any issues at practice clinical meetings and multi-disciplinary meetings. Clinicians were able to prioritise patients according to need and were able to make use of available resources.

We reviewed prescribing for the practice. Staff were appropriately qualified and had opportunities to develop their skills and knowledge base.

We found that the practice engaged and worked in partnership with other services to meet patient's needs in a coordinated and effective manner, including the reviewing of information received from out-of- hours services.

The practice provided a variety of health promotion information for patients, such as smoking cessation, diet and healthy living.

Our findings

Promoting best practice

We spoke with clinical staff about how they received updates relating to best practice from the National Institute for Health and Care Excellence (NICE) or safety alerts they needed to be aware of. We were told that as a teaching practice there were effective systems in place to support this, including a reaccreditation process. Updates were shared at weekly practice meetings or via e-mail, and clinical leads were available for support and guidance for GP registrars should they need them.

The practice carried out audits using the Quality and Outcomes Framework (QOF) to ensure patients with long-term conditions were reviewed. For example, patients with diabetes or asthma were provided with regular review appointments. A gout audit had also taken place and resulted in improved follow-up for patients. Staff carried out assessments of patients' needs and made referrals, as appropriate, to ensure effective care.

Management, monitoring and improving outcomes for people

The GPs we spoke with told us that they held regular review meetings to discuss patient clinical care, and outcomes were explored in line with published guidance. This was reflected in the practice's Quality and Outcome Framework (QOF) Indicator report. QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. For example, the QOF report showed that the provider reviewed referrals for coronary heart disease and cervical screening to improve outcomes for patients.

The GPs at the practice offered joint injections. We saw evidence of an audit for joint injections by one of the GPs with positive outcomes noted for patients. The practice had also completed an audit of patients with gout.

We reviewed prescribing across the practice. The practice was visited every two months by a prescribing advisor from Enfield Clinical Commissioning Group who made recommendations.

We talked with the four partner GPs and the practice nurse, all of whom were knowledgeable about patient's needs. We were provided with examples of where the GPs had demonstrated good practice; for example, in the management of a patient with no fixed abode.

Are services effective?

(for example, treatment is effective)

Staffing

We found that staff received time for education and learning as part of their continuing professional development (CPD). There were weekly practice meetings for clinical staff and, as a training practice, learning was an integral part of these meetings, as was support and supervision of students. We did find, however, that the practice nurse did not currently attend the weekly practice clinical meeting. The practice agreed to review these arrangements.

We looked at the training records and saw that staff had completed training relevant to their role and that this was updated. Examples of training included safeguarding and basic life support. There were appraisal systems in place for staff and systems to monitor when staff training was due. Staff we spoke with were clear about their roles and responsibilities, had access to the practice's policies and procedures and felt supported.

We found that meetings for non-clinical staff were not held on a regular basis, though updates and training, such as safeguarding, were monitored via signed check lists. The practice agreed to review these meeting arrangements.

Working with other services

We spoke with people from a range of other services such as mental health and local supported-living homes, all of whom said they had good working relationships with GPs and staff at the practice. One of the homes we spoke with was very positive about the practice and it's willingness to ensure timely referrals and reviews of medication.

The practice participated in quarterly multi-disciplinary team meetings to discuss complex cases to ensure continuity of care.

We found that information about patients who had contacted the out-of- hours service was reviewed by a GP to determine appropriate appointments and the need for further referral if necessary.

Health, promotion and prevention

New patients were offered an initial consultation to review their social and lifestyle choices, which informed the provision of health advice by clinical staff at the practice. There was a range of health promotion information available at the practice. This included information on smoking cessation, diet, health services for elderly patients and cervical screening tests. Where appropriate, patients were referred to external providers for health and well-being schemes.

We noted that the practice was a high performing practice in a number of areas on the Quality and Outcomes Framework (QOF), for example in cervical screening. The practice encouraged regular screening appointments with the practice nurse for women aged between 25 and 65.

Health promotion was currently GP-led. It was recognized by the practice that greater nurse-led involvement would lead to improvements.

Are services caring?

Summary of findings

Patients received services that were caring.

Patients felt their views were taken into account and that they were treated with dignity and respect. They told us they were involved in decisions about their care and that staff, both clinical and non-clinical, were approachable and listened.

The GP patient survey undertaken in 2014 showed patients felt that the GPs and nurse at the practice treated them with care and respect. We saw where patients did not have the capacity to consent, the practice would act in accordance with legal requirements. Comments on NHS Choices were also largely positive about the caring attitude of staff.

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed positive interactions between staff and patients. Staff had a clear understanding of how they would protect patients' privacy. Consultations took place in rooms with a couch for examinations and blinds to ensure patients' privacy. Signs, explaining that people could ask for a chaperone during examinations if they wanted one, were displayed in the waiting area and on each of the consultation room doors.

We saw that patient confidentiality was respected when care was being delivered and during discussions between staff and patients. Facilities were available for patients to speak confidentially to both clinical and non-clinical staff. There was a sign at reception asking patients to stand back to respect other patients' privacy.

All the patients we spoke with during our visit and the patients who left feedback on the CQC comment cards commented positively about the service in this respect. A 2014 GP patient survey showed that patients felt the GPs and nurse at the practice treated them with care and respect. We saw that where patients did not have the capacity to consent, the practice would act in accordance with legal requirements. Comments on NHS Choices were also largely positive about the caring attitude of staff.

The practice respected patients' religious beliefs. For example, staff ensured that medication containing gelatin was not prescribed to Muslim patients.

Involvement in decisions and consent

Patients told us they had been given adequate time for consultation with their GP. We spoke with seven patients and reviewed 16 comment cards. Each of them told us that the clinician they had seen had taken the time to explain their diagnosis and proposed treatment.

Since the practice was a training practice, some consultations were recorded on video to improve on-going learning. There were separate consent forms for patients for these consultations and it was made clear that patients did not have to consent if they were not happy for a recording to take place. We saw that the recording was stored securely by the practice.

Staff told us there were translation facilities available for people who did not speak English, either through a booked

Are services caring?

interpreter or a telephone language line. We did note that information leaflets at the surgery were not routinely provided in languages other than English; for example, to cater for the large local Turkish population. Also, one patient that we spoke with had recently had an emergency appointment but had not had an interpreter present. The practice said that both issues would be reviewed.

We saw there was a protocol in place to set out how the practice involved people in their treatment choices so that they could give informed consent. There was reference to Fraser guidelines when assessing whether children under 16 years old were mature enough to make decisions without parental consent. Fraser guidelines and the revised Department of Health (2004) guidance for health professionals states that children under 16 years old can be legally competent if they have sufficient understanding and maturity to enable them to understand fully what is proposed.

We looked at the Mental Capacity Act 2005 (MCA) policy for the practice. The MCA 2005 policy contained the contact details for both the independent mental capacity advocate and the community psychiatric team. Staff we spoke with had an understanding of the Mental Capacity Act and of their responsibilities.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice provided a responsive service.

We found that the practice took time to understand the individual needs of patients and made reasonable adjustments where necessary. The service had good arrangements in place to ensure that it could meet patients' needs in a timely fashion.

The practice acted on complaints and concerns from patients and used this to inform improvements to service provision.

Our findings

Responding to and meeting people's needs

Feedback from patients we spoke with on the day of our visit and the comments cards we reviewed showed that the service was responsive to their health-care needs. Where the practice was unable to fully meet the needs of patients, the practice provided information about local support services. For example, since the clinical staff at the practice were all female it had established an arrangement with a local surgery where male patients could be referred for treatment on request if they preferred.

There were systems in place to check that referral letters and test results were sent out in a timely manner to ensure that referral agencies and patients received them promptly. Patients could telephone the practice for test results at specified times during the week, which was explained clearly in the practice leaflet and in reception. Where patients were discharged from hospital, the practice received hospital discharge information by fax or post, depending on the urgency. Systems were in place to ensure buddy cover where GPs were absent from the practice.

Systems were in place for repeat prescriptions, which could be requested on line or by fax or post and by telephone for those patients at greater need.

Access to the service

Patients were offered a range of appointments at the practice from Monday to Friday, with extended hours appointments three evenings per week. The appointments system and number of staff on duty were reviewed regularly to ensure the practice was operating effectively and changes were made if necessary. The practice had taken part in a recent review process to see if they had enough appointments and, as a result, telephone consultations had increased. Most patients told us that the process of accessing appointments was good and that staff at the practice accommodated their changing needs. A small number of patients told us they had difficulty with the telephone system in accessing appointments.

We saw that the premises met the needs of patients with mobility requirements. There was ground floor access to the practice with all consulting and treatment rooms on the same level. The entrance and reception area were big enough for people with either push chairs or wheelchairs. We noted that the practice did not have a low-level

Are services responsive to people's needs?

(for example, to feedback?)

reception desk for wheelchair users. Staff told us that they would move to the front of the reception desk to communicate more effectively with wheelchair users if required. We saw that consulting rooms were sufficiently large and gave access for patients with mobility requirements. There was also a toilet for patients with disabilities. There was sufficient unrestricted on-street parking for patients to access the practice.

Concerns and complaints

There was information on the practice website, in the practice information leaflet and in the reception area about how to raise a complaint or concern. The practice had a complaints policy. They had received nine complaints within the period April 2013 to March 2014. The annual summary showed that all the complaints had been resolved. We spoke to the complaints lead, one of the partner GPs. Complaints were acknowledged and responded to within the timescales set down in the policy and further discussed at weekly practice meetings in order to learn lessons and, if necessary, amend the service. Complaints were reviewed annually by the practice.

Patients told us that they would raise any concerns they had direct with the practice manager, or the GP if more appropriate. Staff told us they tried to resolve complaints immediately and provided patients with a copy of the complaints procedure.

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 well-led.

There was a clear leadership and management structure across the partnership and areas of responsibility were defined. The partners and practice manager we spoke with understood how they needed to take forward the practice to improve patient experiences. The major limiting factor to the practice was the size of the premises, and partners were in the early stages of discussing with the local CCG as to how it might be increased. The practice had begun to develop a formal business plan to support this and it's goal of providing good continuity of care. This process was expected to take up to five years.

We saw that staff had an annual appraisal to enable them to reflect on their own performance with the aim of learning and continuous improvement. Staff we spoke with felt supported. There was evidence of a range of meetings.

There was a commitment to learn from complaints, feedback and incidents. Management put an emphasis on learning from stakeholders, in particular the local Clinical Commissioning Group (CCG), the Patient Reference Group (PRG) and the recently formed Patient Participation Group (PPG).

Our findings

Leadership and culture

There was clear leadership within the practice and defined strategic responsibilities. Clinical leadership was provided across the four GP partners. The partners recognised that the main limiting factor to the practice was the size of the premises. We were told that the practice was discussing this issue with the local CCG. The practice had begun to develop a formal business plan but this process was expected to take up to five years.

Staff we spoke with were aware of their roles and responsibilities and could describe the leadership structure for the service. This included the GP partners and practice manager who shared the responsibilities for the management of the service, and the supervision of clinical and non-clinical staff. Staff said there was an open honest culture within the practice and felt able to raise concerns.

Governance arrangements

The governance arrangements were shared across the four partner GPs at the practice, with defined areas of responsibility such as complaints, training, safeguarding, information governance and infection control.

The GPs and practice manager held weekly formal meetings to discuss the care and treatment of patients and the management of the service. Discussion points included a review of care, patient feedback and significant events and achievement of Quality and Outcomes Framework (QOF) targets. In addition multi-disciplinary meetings were held with other health-care professionals, such as the district nursing team, to promote patient care.

Systems to monitor and improve quality and improvement

The practice had a system in place to undertake clinical audits as part of a quality improvement process to improve patient care in line with guidance provided by the Royal College of General Practitioners and the National Institute for Health and Care Excellence (NICE).

Recent audits included those carried out for joint injections and gout.

The practice was not a member of Urgent Health UK. However, we were told that GPs received external peer reviews though their annual appraisal system.

Are services well-led?

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

In addition, as a training practice, the practice was subject to peer reviews by the London Deanery. We saw that action points from the last deanery inspection (2012) were to develop a patient participation group and to have more whole team meetings. Both of these areas had been progressed.

The practice had participated in internal meetings with the local Clinical Commissioning Group (CCG)to review data on referrals (including irritable bowel and heart failure), emergency admissions and A and E attendances. It had also participated in two external peer review meetings with other practices within the CCG to review pathways and agree areas for improvement.

Patient experience and involvement

The practice had a patient reference group (PRG), a group of 50 patients who had provided the practice with their e-mail addresses and had agreed to share their views. It also had a patient participation group (PPG) of approximately 10 patients, who met regularly to represent the views of patients. The practice undertook regular patient satisfaction surveys and information was available on the practice website or at reception on request. The practice had responded to most comments made on the NHS choices website and had learned from those comments where improvements had been suggested, for example waiting times.

We saw that the PPG were involved in how the practice operated and contributed to any changes required. A recent patient survey identified the need to improve the telephone appointments system and we saw that had been resolved quickly by introducing a telephone queuing system.

Staff engagement and involvement

The practice manager told us and we saw records documenting an annual appraisal system. This gave staff the opportunity to discuss their work and any training and development needs. Staff told us they felt supported. We found there was a willingness at all levels to respond to feedback to improve and enhance services. There was a practice whistleblowing policy and staff we spoke with understood what they needed to do should they witness unprofessional conduct by another member of staff.

Staff we spoke with felt involved in decisions about the practice and were consulted about their views. This included informal discussions about their day-to-day work. We did note that meetings for non-clinical staff were provided on an ad hoc basis and the practice agreed to review this immediately.

Learning and improvement

Staff told us they had access to learning and development opportunities. This included identifying training needs at appraisal or as necessary. Practice meeting minutes showed that clinical staff discussed ways to improve patient care. The practice had a range of systems to gather feedback about performance in order to improve the quality of care for patients. This included looking at complaints and significant events at the practice.

The practice was committed to learning from feedback, compliments and incidents. Management were keen to learn from stakeholders, the PPG and the PRG.

Identification and management of risk

The practice identified risks to the delivery of care and removed or mitigated them before they adversely impacted on the quality of care. Risks were discussed at weekly practice meetings and action to be taken was documented and cascaded to 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 service was responsive to the needs of older patients.

Older patients we spoke with and some of the comment cards we received demonstrated that patients were cared for with dignity and respect and were happy with the care received.

The practice worked with other healthcare professionals and community services to ensure older patients received appropriate assessment, planning and delivery of care.

The practice offered health checks and health promotion advice to patients in this population group. Staff we spoke with demonstrated an awareness of involving older patients and their family or carer in making decisions about their care and treatment.

Our findings

Older patients were able to access the practice via a ramp with hand rails for support. The practice entry doors provided good access, with a sign indicating that additional support was available if needed.

The practice had identified 189 patients who fell into the 'older people' category from the existing patient list so they could respond effectively to their needs. The practice maintained a list of those patients who were housebound to alert staff to any needs. Patients that we spoke with and those who had completed a comment card in this group held positive views about the care they received at the practice.

Older patients were subject to regular reviews by a named GP and were discussed at weekly practice meetings. The practice offered health checks and health promotion advice to older patients, which included blood pressure monitoring and flu vaccinations.Older people could make telephone requests for repeat prescriptions and these were prioritised.

End of life care was discussed with the community palliative team based locally to ensure continuity. The practice maintained a list of family members who were bereaved. GPs made contact with families following bereavement with an alert on the clinical system for staff.

Older patients were represented on the practice PPG.

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 patients with long-term conditions.

Patients with long-term conditions such as diabetes, coronary heart disease (CHD) or osteoporosis were supported with annual, or as required, health checks and medication reviews.

The four partners at the practice operated their own patient lists and had a good knowledge of their patients' needs.

Our findings

The practice has high achievers status in the Quality and Outcome Framework (QOF) for chronic disease management. It offered regular care reviews to patients with long-term conditions. For example, we spoke with a patient with diabetes who said they had been sent for blood tests for glucose every three months and was happy with the care and treatment they received at the practice.

The practice had identified that 2,243 patients from the patient list fell into this population group. It offered health promotion advice including osteoporosis, diet and falls prevention.

Quarterly end of life meetings took place with the community team with weekly practice meetings for clinical staff. The practice also linked in with other support networks, for example Age Concern.

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.

Patients told us that the practice were quick to respond to appointment requests for young children and babies. The service provided appointments for teenage patients who requested confidential advice on contraception and sexual health.

Our findings

Immunisation rates for the practice were good compared with the national average. The practice offered a recall system to ensure that young children were offered full immunisation. The GPs and nurses provided full antenatal and post natal care at the practice. A full range of family planning was offered, including coil fittings. The practice was keen to impact on unplanned teenage pregnancy rates.

In conjunction with health visitors, the practice covered child development checks, with babies' six-week checks being carried out by GPs at post natal appointments. If the practice received a call regarding a child up to the age of 3 months the practice had a policy that a GP would call back within 20 minutes.

The practice had identified that 2,767 patients from the patient list fell into this population group. It had designated staff who were responsible for auditing this population group, using recall letters/texts and alerts put on patient notes.

We were told that the practice referred appropriately to Children's Centres and local food banks where a need was identified. Additionally, the practice offered housing benefit letters without charge and mothers had a choice of hospitals to attend.

We saw that information for this population group was displayed in the waiting area. The practice offered same day appointments to accommodate mothers and retained some appointments for the post- school period to provide additional support.

Working age people (and those recently retired)

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

Summary of findings

The service was responsive to working age population patients and those recently retired.

The service offered bookable appointments, which included early mornings and late evenings three times a week. GPs also offered telephone advice and directed people to appropriate appointments as required.

The practice manager and GP partners audited the appointments system and staff availability to ensure that identified shortfalls in staff or appointment availability were addressed quickly. For example, extra staff had been moved recently to later shifts to cope with extra demand. Information on other health services was also available.

Our findings

Patients in this largest population group were complimentary of the care and treatment received at the practice. Patients were offered choices when referred; for example, a patient was referred to an out of area hospital because it was also their place of work. The practice had identified that 3,888 patients fell into this population group.

Patients over 65 years old were invited for flu vaccinations each year via notifications on prescriptions, text messaging and letters. The practice had a blood pressure machine in the reception area to allow patients to check their blood pressure without the need to book an appointment. It also had information leaflets in the waiting area for this group of people, including information about blood pressure checks.

The practice offered extended opening hours three times per week with extra GP cover. Additional staff had also begun to work in the evenings to cope with high demand at this time. The last two appointments each day were reserved for this group of patients.

The practice was involved in the public health checks programme for patients aged over 40. An on line prescription facility was offered.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The service was responsive to patients in vulnerable circumstances.

Patients we spoke with told us that both the doctors and nursing staff were very helpful and supportive. There was access to drug and alcohol recovery services via the practice and signposting to other voluntary support services.

Our findings

The practice was aware that they had 25 patients in vulnerable circumstances. We were told that the majority lived in two community facilities locally. Some patients in this group, for example, were registered homeless or in temporary accommodation. Patients in this group could also register with no fixed abode.

This patient list was subject to high turnover but the practice endeavoured to improve patients' physical, psychological and social health. This was encouraged by regular consultations at the practice. The practice also liaised with other services to facilitate improved health. There was evidence of signposting to other support services, including the local drug and alcohol assessment team.

We were told that the practice had a good working relationship with other local services caring for patients with learning disabilities, often involving home visits and meetings involving the practice manager had been set up to further improve the quality of care.

The practice offered weekly prescriptions for this patient group. Information leaflets were available in the waiting area regarding fuel payments, carers information and action to take in case of domestic violence.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The service was responsive to patients experiencing poor mental health.

The practice liaised with community mental health teams and clinical psychologists as part of a multi-disciplinary team.

The practice liaised with patients and offered regular reviews of their condition, treatment and medications.

Our findings

The practice had identified that 77 patients from the patient list fell into this population group. This population group was prioritised reducing reducing waiting times to ensure positive outcomes. The practice offered annual health checks and frequent monitoring by GPs for patients in this group. Patients were also discussed at multi-disciplinary meetings held at the practice.

The practice had achieved it's Quality and Outcomes Framework (QOF) targets in this patient group and used care plans to assist other GPs in the surgery to support continuity of care.

We spoke to Enfield Mental Health Services and saw that there were good links with the practice. GPs made referrals to listening and advice centres and endeavored to improve access to psychological therapies for patients.

Staff we spoke with were aware of the need to safeguard vulnerable patients from abuse and the requirements under the Mental Capacity Act 2005. Where a patient could not provide consent staff told us best interest decisions were made with input from other professionals involved in their care.