

Dr Rebecca Hatjiosif

Quality Report

Rutland House Surgery
Rutland House
Haringey
London,
N10 1DU

Tel: 020 8883 82142

Website: www.rutlandhouse.nhs.uk

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

Ratings

Overall rating for this service

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Rebecca Hatjiosif on 20 December 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. All opportunities for learning from internal and external incidents were maximised.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice as comparable to others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from seven examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led.

Good



- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In seven examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.

Summary of findings

- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients, one of the salaried GP specialised in diabetes and the lead GP specialised in mental health.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services, and participated regular teleconferencing with the local hospital to discuss these and high risk patients.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 82% which is comparable to the CCG and national averages of 78%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their

Summary of findings

health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

- The practice nurse watched health promotion videos with patients to help them manage their conditions.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were below average for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and Saturday appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- All students were offered the AWCY meningitis vaccination by the practice nurse.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



- The practice carried out advance care planning for patients living with dementia.
- < >
The practice specifically considered the physical health needs of patients with poor mental health and dementia and the lead GP specialised in this area.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing better than local and national averages. Three hundred and forty eight survey forms were distributed and 116 were returned. This represented 2% of the practice's patient list.

- 81% of patients described the overall experience of this GP practice as good which was similar to both the CCG average of 79% and the national average of 85%.
- 76% of patients described their experience of making an appointment as good which was better than both the CCG average of 67% and the national average of 73%.
- 74% of patients said they would recommend this GP practice to someone who has just moved to the local area which was similar to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 23 comment cards which were all positive about the standard of care received. Patients said they were satisfied with the care they received, felt involved in their care and thought staff were approachable, committed and caring, one patient did mention they had difficulty in getting appointments.

We spoke with four patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring, and thought they received excellent service from the practice.

The friends and family test results showed that 96% (73% nationally) of patients find it easy to get through on the phone and 90% (78% nationally) said they would recommend the surgery to someone new to the area. 99% (95% nationally) had confidence and trust in the last GP they saw or spoke to.

Dr Rebecca Hatjiosif

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser.

Background to Dr Rebecca Hatjiosif

Dr Rebecca Hatjiosif (also known as Rutland House Surgery) is located on Colney Hatch lane, London N10 1DU in a three storey converted house with consulting rooms on the ground and first floor. The premises are owned and maintained by the practice. The practice provides services to approximately 6000 patients. The practice is commissioned to provide services by NHS Haringey Clinical Commissioning Group, through a Personal Medical Services contract (a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract).

The premises have step free access with an accessible toilet and baby changing facilities.

The practice staff includes one principal GP (female) providing six sessions per week, three salaried GP's (two male, one female) providing a total of 15 sessions respectively and a sessional GP (female) providing four sessions. The practice nurse (female) provides four sessions and a Healthcare Assistant (HCA male) providing three sessions per week. The practice manager works full time and there are six administration, reception and secretarial staff working a variety of full and part time hours.

The practice is open from:

- Monday 8am - 8pm
- Tuesday 8am - 8pm
- Wednesday 8am - 6:30pm
- Thursday 8am - 6:30pm
- Friday 8am - 6:30pm

Appointments are from:

- Monday 8:30am - 11:30pm and 4pm - 8pm
- Tuesday 9am - 12pm and 3:30pm - 8pm
- Wednesday 8:30am - 11:30pm and 4:30pm - 6:30pm
- Thursday 9am - 12pm and 3pm - 6:30pm
- Friday 9am - 11:30pm and 2:30 - 6:30pm

Extended hours appointments are offered on Mondays and Tuesdays from 6:30pm to 8pm. Out of hour's services covered by the Haringey GP Collaborative who cover from 6:30pm to 8pm weekdays and 8am to 6pm on Saturdays. Outside of these hours cover is provided by the 111 service.

The practice is registered to provide the following regulated activities, Treatment of disease, disorder or injury; Surgical procedures; Family planning; Diagnostic and screening procedures; Maternity and midwifery services.

Sixty seven percent of the practice population have England as their country of birth, with the next largest group being other European. At 81 years for males and 85 years for females, the average life expectancy is higher than the England averages of 79 and 83 years, respectively. Information published by Public Health England rates the level of deprivation within the practice population group as seven on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

This practice was not inspected under the previous CQC inspection regime.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations give examples to share what they knew. We carried out an announced visit on 20 December 2016.

During our visit we:

- Spoke with a range of staff (GPs, nurse, practice manager and reception staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and family members
- Reviewed a sample of the personal care or treatment records of patients.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service. Looked at information the practice used to deliver care and treatment plans.

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

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

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of seven documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice had two occasions where their networked IT systems went down and they could not access patient records, this meant that clinicians were not able to access the latest patient information. This was discussed at a practice meeting and it was decided that reception would run a backup of files every night and save it onto a hard drive that would be accessible offline.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who

to contact for further guidance if staff had concerns about a patient's welfare, the lead GP was the safeguarding lead. We found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three, the practice nurse level two and the HCA and non-clinical staff level one.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being given to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure

Are services safe?

prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health Care Assistants were trained to administer vaccines and medicines against a Patient Specific Prescription or direction from a prescriber (A PSD is a written instruction, signed by a GP, or non-medical prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis).

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 92% and national average of 95%.

The practice had an overall exception rate of 11% compared to the CCG and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 1 April 2015 to 31 March 2016 showed:

- Performance for diabetes related indicators was higher than the CCG and national averages. 90% of patients with diabetes, on the register, in whom the last IFCC HbA1c is 64 mmol/mol or less in the preceding 12 months compared to the CCG average of 73% and the national average of 78%. The percentage exception reported was 26% which was higher than the CCG average of 15% and the national average of 13%.
- Performance for mental health related indicators was comparable to the CCG and national averages. The

percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 90% which was comparable to the CCG average of 88% and the national average of 89%. The percentage exception reported was 2% which was lower than the CCG average of 5% and the national average of 10%.

95% of patients with COPD had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months compared to the CCG average of 89% and the national average of 90%. The percentage exception reported was 3% compared to the CCG average of 9% and the national average of 12%.

There was evidence of quality improvement including clinical audit:

There had been three clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored. Findings were used by the practice to improve services. For example, the practice conducted a two cycle audit on patients with type two diabetes. The practice's control of HbA1c and blood pressure was above average but their control of cholesterol was below average compared to others in their locality (HbA1c, is a form of haemoglobin (a blood pigment that carries oxygen) that is bound to glucose, the blood test for HbA1c level is routinely performed in people with type two diabetes and lower levels are reflective of how well diabetes is controlled). This was due to the practice's low prescribing of statins (Statins are a class of drugs often prescribed by doctors to help lower cholesterol levels in the blood. By lowering the levels, they help prevent heart attacks and stroke). The practice identified 68% patients who did have optimal control. The practice focused on addressing the patients' cholesterol readings, and where appropriate prescribed statins. The second cycle showed that 74% had optimal control of their diabetes and cholesterol readings and that the changes the practice implemented had produced positive results.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, the nurse had received diabetes, asthma and COPD update training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients

moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation as well as meningitis vaccinations for students.
- Dietetic advice was available on the premises and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 79% and the national average of 81%.

Childhood immunisation rates (for children under 24 months) for the vaccinations given were lower when

Are services effective?

(for example, treatment is effective)

compared to the national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice did not achieve the target in four out of four areas. These measures can be aggregated and scored out of 10, with the practice scoring 7.6 (compared to the national average of 9.1). The immunisations rates for under-five's range from 81% to 96% compared the national average range of 88% to 94%. After the inspection the practice was able to show us evidence that they had been achieving 90% for both under 24 months and under-five's.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. The amount of patients aged between 60-69 who were screened for bowel cancer in the last 30 months was 49% compared to the CCG average of 48% and the national average of 58%. The amount of females aged 50-70 screened for breast cancer in the last 36 months was 57% compared to the CCG average of 63% and the national average of 72%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40-74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could request to be treated by a clinician of the same sex.

All of the 23 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with four patients including four members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. Two of the patients mentioned that they didn't feel that they had enough time in their consultations but were very happy with the standard of care received.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice satisfaction scores on consultations with GPs and nurses was comparable to the CCG and national average. For example:

- 86% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 84% and the national average of 87%.
- 84% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.

- 89% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 88% and the national average of 92%.
- 85% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and the national average of 85%.
- 85% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 83% and the national average of 91%.
- 85% of patients said the nurse gave them enough time compared with the CCG average of 84% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 93% and the national average of 97%.
- 84% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared with the CCG average of 83% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 82% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 81% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

Are services caring?

- 84% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 90%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 77% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 137 patients as carers (2% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on a Monday and Tuesday evening until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Where older patients had complex needs, the practice shared summary care records with local care services, and participated regular teleconferencing with the local hospital to discuss these and high risk patients.
- The practice nurse regularly watched health promotional videos with patients. This enabled the nurse to help patients to understand how to manage their conditions, answer any questions and clear up any misconceptions.
- The practice implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.

- All students were offered the AWCY meningitis vaccination by the practice nurse (the ACWY vaccine offers protection against the four groups of meningococcal bacteria A, C, W and Y).
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had recently trained their receptionist in phlebotomy and immunisation training so that patients can get blood tests and flu jabs done at the practice.

Access to the service

The practice was open between 8am and 6:30pm Monday to Friday and extended hours appointments were offered on Mondays and Tuesdays from 6:30pm to 8pm.

Appointments were from :

- Monday 8:30am - 11:30pm and 4pm - 8pm
- Tuesday 9am - 12pm and 3:30pm - 8pm
- Wednesday 8:30am - 11:30pm and 4:30pm - 6:30pm
- Thursday 9am - 12pm and 3pm - 6:30pm
- Friday 9am - 11:30pm and 2:30pm - 6:30pm

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 78% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 73% and the national average of 76%.
- 73% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 71% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 72% and the national average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 92% of patients said their last appointment was convenient compared with the CCG average of 88% and the national average of 92%.
- 76% of patients described their experience of making an appointment as good compared with the CCG average of 67% and the national average of 73%.
- 38% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 43% and the national average of 35%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

For home visits patients had to call in the morning before 10am and the GP triaged the calls to make an informed decision on prioritisation according to clinical need.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, there was a complaints leaflet available in the reception area.

We looked at seven complaints received in the last 12 months and found that they were dealt with in a timely way, with openness and transparency with dealing with the complaint. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, when a patient's relative complained that their condition had not been diagnosed following a home visit, the practice wrote to the relative and explained the reason why a diagnosis was not made and acknowledged the relative's concern and apologised. This was discussed at a clinical meeting along with making staff more aware of the symptoms and the condition. The GP involved also had further training in the diagnosis and management of the condition.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas, for example the nurse led in the management of long-term conditions.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions including fire, legionella and health and safety risk assessments.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of seven documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held every six months. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

Are services well-led?

Good 

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

- Patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, it was the PPG's suggestion that the practice used text messaging to remind patients of appointments and also to allow patients to cancel them via texts.
- The NHS Friends and Family test, complaints and compliments received.
- staff through annual staff survey, staff away days and staff meetings, appraisals and discussion. Staff told us

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- The practice had recently trained their receptionist in phlebotomy and immunisation training so that patients can get blood tests and flu jabs done at the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.