Highlands Practice

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

Contents

Summary of findings

Overall summary

Highlands Practice is a general practice (GP) surgery that provides NHS services to a registered population of 9110 patients within the Enfield Clinical Commissioning Group (CCG) area.

Enfield CCG is a membership organisation of 54 local GP practices and is responsible for commissioning health services for a population of around 310,000 people. Census data showed that 38.8% of the population belong to non-white minorities which is more than three times higher than the England average (12.3%). Other White (18.2%), Black African (9.0%) and Black Caribbean (5.0%) are the biggest minority groups in the Enfield area.

Highlands practice operates from a single premises located within Florey Square and is currently registered with the Care Quality Commission (CQC) as a partnership of five GPs. We inspected the regulated activities of diagnostic and screening procedures, maternity and midwifery services, surgical procedures and treatment of disease, disorder and/or injury. The practice had a strong and visible leadership, with staff being clear about their roles and responsibilities

Most of the patients we spoke with and comment cards reviewed showed patients were very happy with the quality of care and treatment they had received. This included being treated with kindness and respect on most occasions, involvement in decision making about their treatment planning and delivery, and the cleanliness of the practice.

Most patients also told us they were very unhappy with the appointment service because the appointment availability for non-urgent medical needs was too long a wait, telephone access at 08:00 was difficult and continuity in care was not always maintained as they were unable to see their preferred doctor when needed. The practice was aware of these concerns and had taken action.

We found the GP practice provided a caring service for patients using the service and many aspects of the practice were responsive to patient needs. Most of the patients we spoke with were very complementary about the treatment and care received, and we observed positive interactions between patients using the service and staff.

Appropriate arrangements were in place in relation to involving patients in decisions about their care and service provision, safeguarding people from abuse, management of medicines and the maintenance of suitable equipment. The practice maintained good working relationships with local health community services and multi-disciplinary professionals to ensure appropriate care and treatment was delivered.

However, some improvements were required to ensure the practice provided a safe, effective and well-led service. For example, the practice did not have up to date and completed clinical audit cycles to inform the quality improvement process, appropriate checks had not been undertaken before staff began work to ensure patients were cared for by suitable staff and some records related to the management of the service and staff employed were not available for us to assess on the day of the inspection.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Most of the patients we spoke with felt safe when using the service and raised no concerns about their safety at the practice. The GP practice had suitable arrangements in place for dealing with foreseeable emergencies, equipment maintenance and the safe storage of emergency medicines and vaccinations. The practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

However, disclosure and barring checks (DBS) and / or appropriate risk assessments had not been completed for most staff members. Records relevant to staffing and recruitment of most staff could not be located when requested. The infection control arrangements in place did not fully protect people from the risk of infection.

Are services effective?

The GP practice had arrangements in place to monitor and improve patient health outcomes through discussions held during practice clinical meetings and external peer review meetings. These meetings took into account evidence based best practice in line with published guidance.

The practice worked in collaboration with other multi-disciplinary professionals to coordinate integrated care pathways for patients using the service. Health promotion advice and patient leaflets on healthier lifestyles were available for people to access.

However, up to date training records were not available on the day of our inspection to demonstrate the training staff had attended.

Are services caring?

Patients we spoke with during our inspection were mostly positive about the care provided. Most patients told us staff were caring and treated them with dignity and respect. A few patients told us some reception staff and GP's had been "unhelpful" in their dealings with them and this was shared with the provider for review.

We observed staff being polite and professional in their interactions with patients. Patients were involved in making decisions about their care and treatment, and appropriate information was given to help them understand the choices available on most occasions.

The practice had systems in place to ensure consent was obtained before patients received any care or treatment and staff demonstrated awareness of acting in accordance with legal requirements where patients did not have the capacity to consent.

Summary of findings

Are services responsive to people's needs?

Many aspects of the practice were responsive to patients' needs. This included, the practice meeting the specific needs of patients: travelling abroad, living in care homes and requiring emergency and home visit appointments.

The practice had good collaborative working arrangements in place with other health and social care services to ensure patient care needs and request for medicines were responded to in a timely way.

The practice was accessible to patients with limited mobility and interpreting services were available for patients' whose first language was not English. There was a complaints system in place and complaints raised were considered and responded to in writing.

Most patients we spoke with told us it was difficult to pre-book a non-urgent appointment by telephone and to see their preferred doctor. This feedback was shared with the practice and was acknowledged as an on-going improvement area; and some action had been taken to improve the appointments booking system.

Are services well-led?

The service was well-led in most respects.

Patients who used the service were asked for their views about care and treatment, and they were acted upon on most occasions. The practice had an active Patient Participation Group that met every three months to discuss service provision.

There was a strong and visible leadership, with staff being clear about their roles and responsibilities. A culture of openness was promoted and staff felt valued. However not all staff had shared vision and values although there was an expectation of high standards of patient care.

Governance arrangements in place were used to drive improvement and quality assurance, but some aspects required further development.

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 had arrangements in place to respond to the needs of patients aged 75 and over.

Older people we spoke with and comment cards received showed people were cared for with dignity and respect and they were happy with the care provided.

The practice worked with multi-disciplinary professionals and community services to ensure older people received appropriate assessment, planning and delivery of care within their own homes and care homes. Physical health checks and health promotion advice was also provided to patients.

Staff we spoke with demonstrated an awareness of involving older people and their next of kin and / or carer in making decisions about their care and treatment.

People with long-term conditions

The practice had arrangements in place to meet the needs of this population group.

Regular clinics and patient care reviews were held with other multi-disciplinary professionals to ensure patients with long term conditions received coordinated care. Appropriate referrals to community services for specific diagnosis such as diabetes, musculoskeletal conditions and dementia were made.

Some areas required improvement including involvement from the palliative care team for patients receiving end of life treatment.

Mothers, babies, children and young people

The practice had arrangements in place to meet this population group.

Most of the patients we spoke with and comment cards received showed that patients were satisfied with the nursing and midwifery care provided, and felt the service was caring and responsive. There were appropriate arrangements in place to safeguard mothers, babies, children and young people from abuse and ensure they received immunisations, antenatal and postnatal checks in line with national guidance.

Summary of findings

Medicines such as vaccinations and immunisations were effectively managed. Information relating to external support groups and community services provided for this population group were displayed on the communal noticeboards and available for patients to access.

The working-age population and those recently retired

The practice had arrangements in place to respond to this population group.

Feedback received from patients was mostly positive about the way staff treated them and the care received. However, some patients felt improvements were required to the appointment booking system to reduce the waiting period for non–urgent appointments and for clinic times to be varied and include access outside working hours.

The provider had effective systems in place for the safe management of medicines and joint working processes with multi-disciplinary professionals within primary and secondary care services. This ensured appropriate referrals, treatment and care were provided for working age people with long term conditions.

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

The practice had arrangements in place to meet the needs of this population group.

The practice maintained a register for people with learning disabilities as a source of information to inform the monitoring of their care needs. Clinical staff we spoke with told us annual health checks and care planning for people with learning disabilities were undertaken with their carers and / or next of kin.

Staff we spoke with demonstrated awareness of the provider's safeguarding policies and knew what action to take if they needed to raise an alert.

People experiencing poor mental health

The practice had arrangements in place to meet the needs of this population group.

The practice had arrangements in place to provide effective and coordinated care in liaison with community mental health professionals. A register for patients with mental health needs was maintained to inform the regular monitoring of their health needs, and ensure people were contacted and recalled to the practice when appropriate.

Summary of findings

The GP practice provided care services to people with mental health needs living in local supported accommodation and care homes. Staff that we spoke with had an awareness of the Mental Capacity Act 2005 and Mental Health Act 1983, and implications for consent to treatment.

Summary of findings

What people who use the service say

During our inspection we spoke with 24 people using the service aged between 17 and 85 years with a variety of life-stage and ethnic backgrounds. All the people we spoke with were happy with the care they received. The majority of them (21) were happy to see any doctor at the practice. People told us they were involved in decisions about their treatment and were happy with the accessibility of the practice, the general ambience of the waiting room environment and the cleanliness.

However, 14 out of 24 patients told us they were unhappy with the appointment booking service and mentioned the difficulty of getting through by phone at 08:00 to obtain an on the day appointment. In addition, some patients told us they were unable to make routine / advance appointments within two days and / or see their preferred doctor when needed. Of the 22 comment cards we reviewed, 20 were complementary about the services provided, and four of them stated improvements were required to the appointment system and the attitude of some staff.

Areas for improvement

Action the service MUST take to improve

- Ensure that the relevant pre-employment checks are carried out for all staff and appropriate records are maintained.
- Ensure that clinical audit cycles are completed in line with best practice and are up to date to improve patient care, treatment and outcomes.
- Ensure a Legionella Risk Assessment is undertaken.
- Improvements are required in relation to the regulations related to recruitment of staff, assessing and monitoring the quality of service provision and records.

Action the service COULD take to improve

- A hearing loop system and access to British Sign Language services to support communication for patients with sensory impairments.
- An automated external defibrillator (AED) for use in resuscitation and / or a medical emergency.
- Information directing patients to the “blue file” containing the Patient Participation Group meeting minutes and a summary of decisions made at the previous meeting.

Good practice

Our inspection team highlighted the following areas of good practice:

- The provider worked in partnership with the Patient Participation Group to improve service delivery.
- The GPs facilitated regular clinical practice meetings to review and improve the delivery of care for patients registered with the practice.
- Collaborative working and periodic meetings were held with multi-disciplinary health and social care professionals to promote integrated care for people using the service.

Highlands Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP, and the team included a Pharmacy Inspector and an Expert by Experience. They were all granted the same authority to enter Highlands Practice as the CQC inspector.

Background to Highlands Practice

Highlands Practice provides NHS services to a patient list of 9110. The practice is located in the London borough of Enfield and operates from a single premises located within Florey Square.

The service is registered with the Care Quality Commission (CQC) as a partnership of five GPs, to provide the regulated activities of Diagnostic and screening procedures, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder and / or injury. A Statutory Notification related to partnership changes had been received prior to our inspection and an updated Certificate of Registration was yet to be issued to the provider.

The staffing structure comprised of four GP partners, three other GPs, two practice nurses, one healthcare assistant, a practice manager, an operations manager and eleven clerical staff. Highlands Practice is a teaching practice and at the time of our inspection there was one GP Registrar in training.

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 is why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. This included the Clinical Commissioning Group (CCG), NHS England and Healthwatch.

Detailed findings

We carried out an announced visit on 28 May 2014. During our visit we spoke a member of the Patient Participation Group and 24 patients using the service. The patients were aged between 17 and 85 years with a variety of health care needs and from different ethnic backgrounds. We also spoke with a range of staff (GP partners, Health Visitors, Practice Nurse, Registrar / trainee GP, Practice Manager, Operations Manager, Health Care Assistant, reception and clerical staff) and other healthcare professionals (health visitors and district nurses) based at the practice.

We observed how people were being cared for and talked with carers, family members and reviewed information; including the provider's policies and procedures, clinical audits, minutes of meetings, staff records and reports shared with NHS England and Enfield CCG. We reviewed 22 comment cards where patients shared their views and experiences of the service.

Are services safe?

Summary of findings

Most of the patients we spoke with felt safe when using the service and raised no concerns about their safety at the practice. The GP practice had suitable arrangements in place for dealing with foreseeable emergencies, equipment maintenance and the safe storage of emergency medicines and vaccinations. The practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

However, disclosure and barring checks (DBS) and / or appropriate risk assessments had not been completed for most staff members. Records relevant to staffing and recruitment of most staff could not be located when requested. The infection control arrangements in place did not fully protect people from the risk of infection.

Our findings

Safe patient care

The practice had systems in place to report and record safety incidents, complaints and safeguarding concerns to ensure safe patient care was maintained. Staff we spoke with demonstrated awareness of their role in reporting these concerns and lessons learnt were shared with staff.

Learning from incidents

The practice maintained a record of significant events and these were discussed at clinical meetings to identify the learning for the practice. For example, critical incidents relating to medicines were recorded and appropriate action was taken including discussion of the concerns at the GP partnership meetings. However, not all the information was recorded on the significant forms but learning outcomes were noted in minutes of meetings.

Safeguarding

The provider had policies in place relating to the safeguarding of vulnerable adults and child protection, acceptance of gifts and donations and whistleblowing. One of the GP partner's was the designated safeguarding lead for the practice.

Processes in place for reporting and dealing with safeguarding issues were visually displayed for staff reference. Staff we spoke with were aware of their duty to report any potential abuse or neglect to safeguard patients using the service.

We saw six certificates to confirm that non-clinical staff had completed training in child protection, introduction to safeguarding vulnerable adults and young people. However, we were unable to verify that all clinical staff (GPs and nurses) had attended the relevant level of child protection training due to the absence of staff training records.

Monitoring safety and responding to risk

GPs we spoke with told us there were arrangements in place for assessing and responding to individual patient risk. This included monitoring patients prescribed high risk drugs, reviewing child protection reports / plans with other multi-disciplinary professionals, and reviewing clinical and non-clinical staffing levels to meet people's needs.

Are services safe?

Medicines management

The practice had policies and procedures in place to support the safe management of medicines. Most medicines we looked at were securely stored and vaccinations were kept in a locked fridge.

Fridge temperatures were recorded daily to evidence vaccinations had been stored safely within the manufacturer's recommended temperature ranges of between two and eight degrees Celsius. Clinical staff had support from the Clinical Commissioning Group (CCG) Prescribing Advisor and the community pharmacist located adjacent to the surgery.

The practice nurses administered vaccines under an individual protocol which had been verified by a senior GP partner. All batch numbers of vaccines and expiry dates were recorded on the patient's individual electronic record. This ensured an audit trail of the handling, safe keeping and administration of medicines.

Cleanliness and infection control

Patients we spoke with told us the premises were always clean when they visited and we observed the practice to be visually clean. Facilities for hand washing, hand cleaning gel and paper towels were available.

The provider had an infection prevention and control lead. Staff we spoke with were aware of infection control guidelines and a cleaning schedule and cleaning audit were available. However we were unable to confirm that all relevant staff had received infection and control training as training records were not available when requested.

We found there was no Legionella risk assessment and checks in place to identify and manage any risks in the water system. The requirement to undertake this assessment had been identified in a premise survey completed in February 2013; and we found this action had not been completed to protect patients, staff and others who may have been at risk.

Staffing and recruitment

The GP practice did not have an effective system in place to ensure that appropriate checks were undertaken before staff began work. The three staff records we looked at showed that pre-employment checks such as proof of identity, a recent photograph, right to work verification, criminal record checks, two references and occupational health checks had not been undertaken in line with the provider's recruitment policy.

The Practice Manager told us criminal record checks had not been undertaken for non-clinical staff and / or risk assessments to ensure they were suitability for the role; however plans were in place for the checks to be undertaken at the time of our inspection.

Dealing with Emergencies

The practice had procedures in place to deal with potential medical emergencies. Three staff records we looked at showed staff had received training in cardio-pulmonary resuscitation, use of a defibrillator and / or emergency first aid. We were unable to confirm if all staff had received up to date training due to an absence of staff training records.

The practice kept an oxygen cylinder and medicines for emergency use. Emergency drugs and equipment checked were in date but records of checks for out of date stock were inconsistent and there was no evidence that they were done regularly. Practice staff knew the contents of emergency boxes and anaphylactic kits but there was no ready visual identification for a locum or new member of staff.

Regular fire drills were undertaken to ensure staff were aware of the evacuation procedures.

Equipment

There were suitable arrangements in place to ensure equipment was properly maintained and suitable for its purpose. Portable appliance testing for electrical equipment and the servicing of medical equipment had been undertaken by external companies within the last 12 months.

Are services effective?

(for example, treatment is effective)

Summary of findings

The GP practice had arrangements in place to monitor and improve patient health outcomes through discussions held during practice clinical meetings and external peer review meetings. These meetings took into account evidence based best practice in line with published guidance.

The practice worked in collaboration with other multi-disciplinary professionals to coordinate integrated care pathways for patients using the service. Health promotion advice and patient leaflets on healthier lifestyles were available for people to access.

However, up to date training records were not available on the day of our inspection to demonstrate the training staff had attended.

Our findings

Promoting best practice

The practice participated in external peer review meetings where care pathways and data on outpatient referrals, emergency admissions and A&E attendances were discussed. The records we looked at detailed the learning points agreed and the specific action taken by the practice to improve positive outcomes for people's health.

The GPs also reviewed the outcomes of implementing care pathway guidelines for menorrhagia, urinary incontinence and heart failure to ensure care and treatment was delivered in line with national guidance.

The practice's computer systems prompted GP's to review patients' medication at the required intervals so that their effectiveness could be monitored. Effective systems were in place for patients to order their repeat prescriptions in a timely manner.

Management, monitoring and improving outcomes for people

The practice did not have an effective system in place to undertake completed clinical audits as part of a quality improvement process to improve patient care in line with professional guidance provided by the Royal College of General Practitioners and National Institute for Health and Clinical Excellence (NICE).

For example, the audit cycles related to repeat prescribing of medicines, referral for endoscopy and Vitamin D Deficiency we looked at were not completed and therefore could not assess the implemented changes and improvements made. One of the GP partners acknowledged that some completed clinical audits were not readily available on the day of our inspection because some GPs kept them as individual records as part of the revalidation of their practice.

GPs we spoke with told us peer review meetings were regularly held to discuss patient clinical care and evidence based outcomes were explored in line with published guidance. This was reflected in the practice's 2013/14 Quality Outcome Framework (QOF) Indicator report and practice meeting minutes we looked at – (Quality Outcome Framework is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients).

Are services effective?

(for example, treatment is effective)

For example, the QOF report showed the provider reviewed the appropriateness and outcome of referrals made to community services such as gynaecology, ophthalmology and the mental health crisis teams to improve outcomes for patients. However, the practice acknowledged the outcome of hospital referrals were not always known as the local hospitals did not always provide a discharge letter unless requested.

Staff told us discharge letters received from patient visits to hospital and out of hours' services were scanned into the practice's computer systems and if the patient's own GP was not available the information was shared with another GP.

Staffing

The practice had identified mandatory training modules to be completed by staff and specific training relevant to clinical staff. This included safeguarding children and young people, and cardio pulmonary resuscitation (CPR). The Practice Manager told us staff kept their professional development files with them or at home. As a result most files were not available when requested during the inspection or a training schedule detailing the training completed by all staff. This arrangement did not ensure that appropriate records were retained for staff employed by the service.

The three staff records we looked at showed all staff had received an annual appraisal and had completed refresher training in relation to safeguarding vulnerable adults and young people, and cardio pulmonary resuscitation for example. However, we were not provided with suitable information to demonstrate that the provider had systems in place to monitor training requirements for both clinical and non-clinical staff and maintain adequate documentary evidence of training attended and/or induction completed.

Staff we spoke with told us they were clear about their roles and responsibilities, had access to the practice policies and procedures, and were supported to attend training courses appropriate to the work they performed. One staff member told us they had been supported to obtain further qualifications to progress from a clerical role to a healthcare assistant role, and the GP Registrar we spoke with was complementary of the training and support they had received.

Working with other services

The practice engaged with other health and social care providers to ensure a collaborative and multi-disciplinary approach to patient care and treatment. Minutes of meetings we looked at demonstrated that people's specific care needs and outcomes had been reviewed.

Two of the health visitors we spoke with told us they had positive relationships with the GPs and found the GP practice effective in ensuring referrals for home visits and reviews of medications were undertaken in a timely manner.

Health, promotion and prevention

All new patients were offered an initial consultation to review their social and lifestyle histories which informed the provision of health promotion advice and support by clinical staff.

The practice offered a range of health promotion services for both children and adults, and written information to support people live healthier lives was available for them to access. This included immunisations for babies and children, vaccinations for adults, smoking cessation schemes and cervical screening tests. Where appropriate, patients were also referred to external organisations for health and well-being schemes.

Are services caring?

Summary of findings

Patients we spoke with during our inspection were mostly positive about the care provided. Most patients told us staff were caring and treated them with dignity and respect. A few patients told us some reception staff and GP's had been "unhelpful" in their dealings with them and this was shared with the provider for review.

We observed staff being polite and professional in their interactions with patients. Patients were involved in making decisions about their care and treatment, and appropriate information was given to help them understand the choices available on most occasions.

The practice had systems in place to ensure consent was obtained before patients received any care or treatment and staff demonstrated awareness of acting in accordance with legal requirements where patients did not have the capacity to consent.

Our findings

Respect, dignity, compassion and empathy

Most of the patients we spoke with told us staff treated them with kindness and were happy with the care and treatment they received. A few patients told us improvements were required in relation to the attitude of reception staff when booking appointments and requesting repeat prescriptions as staff were described as being "unhelpful" on some occasions. We observed good interactions between staff and patients using the service, and staff spoke politely to patients on the telephone.

Staff we spoke with demonstrated awareness of the practice's policy regarding patient and information confidentiality, and could describe how they worked to ensure that patient's privacy was maintained. Patient consultations took place in lockable and / or closed rooms to ensure their privacy and dignity was maintained.

A chaperone service was offered by the practice and guidelines were in place for staff to provide support when required. A private room was also available for patients to discuss confidential issues and / or use whilst waiting for their appointment.

Involvement in decisions and consent

Most patients we spoke with told us they were involved in decisions about their treatment and confirmed their consent had been obtained before they received any treatment. A few patients felt some doctors did not always listen to their health needs. GP partners we spoke with told us if patients were not happy with the service they could make a formal complaint to ensure their concerns were addressed. Patient leaflets were displayed on noticeboards to promote services provided by the practice, external organisations, support groups and health promotion advice.

Staff we spoke with demonstrated an understanding of obtaining verbal and written consent in relation to patients care and treatment. For example, one of the GP partners told us they were aware of the need to use their professional judgement and Gillick competence when assessing whether a young person had the maturity to understand the nature of proposed medical treatment, risks involved and the benefits before consent was sought from them and/or their parent.

Are services caring?

There were arrangements in place to secure the consent of patients who lacked capacity in relation to specific decisions such as end of life care and resuscitation and this involved best interest discussions with family, carers, and professionals involved in their care. Although some clinical staff told us they had undertaken training related to the Mental Capacity Act 2005 and Mental Health Act 1983, the practice was unable to provide us with the training they had undertaken.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Many aspects of the practice were responsive to patients' needs. This included, the practice meeting the specific needs of patients: travelling abroad, living in care homes and requiring emergency and home visit appointments.

The practice had good collaborative working arrangements in place with other health and social care services to ensure patient care needs and request for medicines were responded to in a timely way.

The practice was accessible to patients with limited mobility and interpreting services were available for patients' whose first language was not English. There was a complaints system in place and complaints raised were considered and responded to in writing.

Most patients we spoke with told us it was difficult to pre-book a non-urgent appointment by telephone and to see their preferred doctor. This feedback was shared with the practice and was acknowledged as an on-going improvement area; and some action had been taken to improve the appointments booking system.

Our findings

Responding to and meeting people's needs

Feedback from patients we spoke with and comment cards reviewed showed the service was responsive to patient needs on most occasions. The practice had systems in place to ensure an initial health assessment of new patients registered with the practice was carried out. For example, new patients completed a lifestyle questionnaire which provided important information about their medical history, current health concerns and lifestyle choices. Each patient was offered an appointment with the healthcare assistant and / or practice nurse for a health check and health promotion advice before being seen by the GP in relation to their presenting medical needs.

The practice provided a GP service to support people in care homes and supported living accommodation; and GPs worked in collaboration with the care homes team in the planning and provision of patients care and treatment. There were systems in place to prioritise emergency and home visit appointments for patients who were not well enough to attend the surgery. This included on the day appointment with a duty doctor for most patients, and after 18:30, people could access the out of hour's services and / or 24 hour nurse led NHS 111 helpline.

A travel clinic service was also provided and a comprehensive medical questionnaire was completed by patients before they gave their consent for vaccinations. This ensured that patients received appropriate care that met their needs. A phlebotomist visited the practice twice a week so that patients had their blood tests taken locally rather than having to go to the hospital.

Access to the service

The GP surgery is wheelchair accessible and has lift access to the first floor consulting rooms. Staff told us they had access to an interpreting service for patients' whose first language was not English and additional time appointments were made for people who required an interpreter for their consultation.

Records we looked at showed the practice had audited the appointment system in March 2013 as part of "Improving access to a GP practice in Enfield Programme 2013"; and had achieved an access score of 59%. The audit findings

Are services responsive to people's needs?

(for example, to feedback?)

showed too few appointments were available for advance bookings and patients using the service were unable to book in advance with the doctor of their choice for example.

These findings were supported by 14 out of 24 patients that we spoke with during the inspection, including the difficulty of getting through the phones at 08:00. Patient feedback included suggestions to increase staffing levels to take calls at 08:00, having a phone system that tells a person the number they are in the queue and telephone options for different services such as appointments, prescriptions and test results. We saw that a number of patients had also posted negative comments about the appointment system on the NHS Choices website.

This feedback was shared with the provider and they acknowledged patient concerns about the appointment system were regularly reviewed and was an improvement area for the practice. The provider showed us records to demonstrate that systems were in place to monitor the appointment system. This included an action plan that had been implemented from May 2013. Patient Participation Group (PPG) meeting minutes showed the appointment system had been discussed and further changes to the appointment system had been planned from 01 June 2014 to improve patient access to the service.

Improvement actions included increasing appointment availability, non-urgent appointments being bookable a month in advance and offering telephone consultations to increase access to a GP where appropriate. The practice also acknowledged their current phone line system was a limiting factor in relation to the volume of calls they could handle. For example, the provider had four incoming lines to the practice and were unable to obtain more lines through their BT connection at the time of our inspection.

Concerns and complaints

The practice leaflet and posters on some of the noticeboards provided patients with information about how to make a complaint within the service and / or contact details for NHS England. We reviewed a summary of complaints patients had made and the practice's response. The information showed the practice maintained a log of complaints which included; the date the complaint was received and acknowledged; the outcome of the investigation and the date the complaint was closed.

The practice completed an annual complaints review report which analysed themes and improvements required to improve the service provision. However, we found the annual review of 2013/2014 complaints had not been completed.

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 in most respects.

Patients who used the service were asked for their views about care and treatment, and they were acted upon on most occasions. The practice had an active Patient Participation Group that met every three months to discuss service provision.

There was a strong and visible leadership, with staff being clear about their roles and responsibilities. A culture of openness was promoted and staff felt valued. However not all staff had shared vision and values although there was an expectation of high standards of patient care.

Governance arrangements in place were used to drive improvement and quality assurance, but some aspects required further development.

Our findings

Leadership and culture

Two GPs we spoke with told us it was the practice culture to place emphasis on good clinical care and they acknowledged that management records were not always maintained to support the leadership priorities and development strategies in place. One GP told us the practice's priorities were also informed by the strategic goals for Enfield Clinical Commissioning Group. This included commissioning care in a way which promoted integration between health, primary, community and secondary care and social care services.

Staff we spoke with were aware of their roles and responsibilities and could describe the leadership structure of the service. This included four GP partners and a practice manager who together shared the responsibilities for the management of the service, and the supervision of both clinical and non-clinical staff. This information was also contained in the practice patient leaflet. Staff told us an open and honest culture was promoted within the practice. Although there was agreement amongst staff to deliver a high standard of care to patients, not all staff had shared vision and values.

Governance arrangements

The provider had staff leads for different aspects of clinical governance including medicines management, infection prevention and control and information technology.

The GP partners and Practice Manager held formal meetings twice monthly to discuss the care and treatment of patients, and the management of the service. Discussion points included the review of specific areas of care such as integrated care for people over 75 years, patient feedback, complaints, significant events and achievement of Quality Outcomes Framework (QOF) targets.

In addition, periodic multi-disciplinary meetings were held with allied health and social care professionals such as health visitors and the district nursing team to promote integrated care and good outcomes for patients' health.

Systems to monitor and improve quality and improvement

The systems to monitor and improve quality required further development. Although the practice participated in peer review meetings where clinical care was discussed their clinical audit programme required improvement. The

Are services well-led?

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

clinical records we looked at showed most of the clinical audits had been undertaken between 2010 and 2013 and the audit cycles were incomplete. We could not assess if any changes had been or if any re-audits had taken place. Most of the audits were often not specific in relation to the periods / dates they related to, the criteria, standards and targets used for performance measurement and evaluation.

Patient experience and involvement

The practice had a Patient Participation Group (PPG) in place which aimed to meet every three months to discuss patients' experiences of using the service and areas of improvement.

The PPG meeting dates were displayed on the communal noticeboards and a folder with the meeting minutes were available in the waiting room areas. However, the agreed outcomes from the PPG meetings were not displayed to ensure that patients could see that they were being listened to and involved in the delivery of the service. Only one patient we spoke with showed awareness of the PPG and the meeting minute's folder; and highlighted that the practice was not meeting the two day appointment system as detailed in the PPG meeting notes.

Staff engagement and involvement

Most staff we spoke with told us they felt involved in decisions about the practice and were asked for their feedback about the service delivery. This included attending practice meetings internal peer reviews and informal discussions about their day to day work. However, it was not always clear from the minutes of the practice meetings if all the issues discussed had been followed up.

Learning and improvement

Staff told us they had access to learning and development opportunities, this included identifying training needs as part of their annual appraisal. However, the practice was unable to provide evidence of the training completed by most staff. Practice meeting minutes we looked at showed clinical staff discussed ways to improve care and treatment for patients.

The provider had a range of mechanisms in place to obtain feedback about performance, quality of care provided and patient experiences to improve the quality of services provided. This included investigating complaints received and significant events.

Identification and management of risk

The practice had assessed risks that could impact the management of the service. This included a business continuity plan which identified and assessed risks related to computer systems failure, staff absences, loss of utilises such as water and electricity, for example and relevant staff showed awareness of this plan.

Older people

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

Summary of findings

The practice had arrangements in place to respond to the needs of patients aged 75 and over.

Older people we spoke with and comment cards received showed people were cared for with dignity and respect and they were happy with the care provided.

The practice worked with multi-disciplinary professionals and community services to ensure older people received appropriate assessment, planning and delivery of care within their own homes and care homes. Physical health checks and health promotion advice was also provided to patients.

Staff we spoke with demonstrated an awareness of involving older people and their next of kin and / or carer in making decisions about their care and treatment.

Our findings

Older people we spoke with told us they were happy with the care they received but felt improvements were required to ensure an effective appointment system was in operation. Patients told us they were treated with dignity and respect, and this was confirmed when we observed staff being polite and courteous when supporting them on the day of our inspection.

Records showed home visits were undertaken by the duty GP for older people who were not well enough to attend the surgery and a system was in place for assessing the support needs of their carers. A weekly GP service for older people living in a local nursing home was also provided.

GPs we spoke with told us older people were referred to the community homes team for multi-disciplinary intervention from a community matron, psychologist and geriatrician where appropriate. One of the GP partner's told us the practice worked towards ensuring older people could be seen by their named GP in line with the national programme for named GP's for people over 75's.

Health checks and health promotion advice were provided for older people with long term conditions and / or with good health. This included annual physical health checks, blood pressure monitoring, memory check and flu vaccinations.

Management records we looked at showed GPs held external peer review discussions and considered the impact of using elderly assessment units as ways of reducing older people attendances at A&E and hospital admissions. The provider's 2013/14 Quality of Framework report stated the provider maintained a falls register and several patients had been referred to the falls clinic for rehabilitation to prevent avoidable hospital admissions and to ensure they received on-going monitoring from the community team.

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 practice had arrangements in place to meet the needs of this population group.

Regular clinics and patient care reviews were held with other multi-disciplinary professionals to ensure patients with long term conditions received coordinated care. Appropriate referrals to community services for specific diagnosis such as diabetes, musculoskeletal conditions and dementia were made.

Some areas required improvement including involvement from the palliative care team for patients receiving end of life treatment.

Our findings

Feedback received from patients within this population group demonstrated most patients were satisfied with the care they had received and were involved in the planning and delivery of their care. Some patients told us improvements were required to the appointment system to ensure a consistency of care with their preferred doctor and to reduce the waiting period for non-urgent appointments. For example, some people commented they found it frustrating having to see different doctors and repeat their medical history and wished they could develop a relationship with a chosen doctor.

People with long term conditions such as asthma, breathing disorder and diabetes could access related clinics at the surgery on an appointment basis. Multi-disciplinary meetings were held with other professionals to ensure integrated care for people with long term conditions; although there was limited involvement from the palliative care team who had been invited to the practice meetings.

There were effective systems in place to undertake regular blood tests for people and monitor repeat prescriptions for various medicines used in the treatment of long term conditions such as atrial fibrillation (a heart condition) and rheumatoid arthritis. A phlebotomist visited the practice twice weekly so that patients were able to have blood tests undertaken locally rather than going to hospital.

The provider's 2013/2014 Quality of Framework achievement report showed the practice achieved maximum points for the management of conditions such as heart failure, osteoporosis and rheumatoid arthritis and improvements were required for secondary prevention of coronary heart disease and hypertension for example.

Patients with chronic obstructive pulmonary disease (COPD) were regularly reviewed based on assessment of

People with long term conditions

need, and appropriate management plans included people being provided with rescue medication packs, referral to the community respiratory and intermediate care teams for pulmonary rehabilitation where appropriate.

Mothers, babies, children and young people

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

Summary of findings

The practice had arrangements in place to meet this population group.

Most of the patients we spoke with and comment cards received showed that patients were satisfied with the nursing and midwifery care provided, and felt the service was caring and responsive. There were appropriate arrangements in place to safeguard mothers, babies, children and young people from abuse and ensure they received immunisations, antenatal and postnatal checks in line with national guidance.

Medicines such as vaccinations and immunisations were effectively managed. Information relating to external support groups and community services provided for this population group were displayed on the communal noticeboards and available for patients to access.

Our findings

We received positive feedback in relation to the overall care provided for this population group and some mixed responses in relation to the accessibility of appointments. For example one mother felt improvements were required to ensure that children under the joint care of the GP and hospital had access to a named GP for continuity in care.

The provider held a weekly baby clinic on a Wednesday and services provided included an eight week developmental check, physical health checks and immunisations in line with national guidance. An antenatal clinic was offered every Tuesday with support from the community midwife and all the clinics were accessed by appointment only.

The health visitors' team was based within the practice and this facilitated integrated communication and responsiveness to the needs of this population group. Appropriate arrangements were in place for the effective management of patient medicines including vaccinations and immunisations.

The provider had policies in place to safeguard babies, children and young people from abuse. Staff we spoke with had a good working knowledge of child protection issues and the guidelines in place for raising an alert when concerned. GPs we spoke with told us a code and alert system was used to record any safeguarding concerns for each patient within this population group; and they worked together with professionals such as the community midwife, health visitors and social workers in the planning, delivery and monitoring of people's care.

Working age people (and those recently retired)

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

Summary of findings

The practice had arrangements in place to respond to this population group.

Feedback received from patients was mostly positive about the way staff treated them and the care received. However, some patients felt improvements were required to the appointment booking system to reduce the waiting period for non–urgent appointments and for clinic times to be varied and include access outside working hours.

The provider had effective systems in place for the safe management of medicines and joint working processes with multi-disciplinary professionals within primary and secondary care services. This ensured appropriate referrals, treatment and care were provided for working age people with long term conditions.

Our findings

The services available for this population group included registration health checks, healthy lifestyle advice, clinics related to smoking cessation and family planning for example. However fitting of contraceptives such as mirena coil were not provided at the practice and people were referred to other services.

Records we looked at showed the provider had implemented changes to the appointment system to enable people within this population group to have better access to the service. For example, GP telephone consultation appointments were increased for people who were unable to attend a face to face appointment due to work commitments. However, patient feedback received and comments noted on the NHS Choices website showed it was not easy to book a suitable appointment outside working hours.

Multi-disciplinary meeting minutes we looked at showed GPs reviewed care pathways related to referrals, emergency admissions and A&E attendances for people within this population group. The minutes detailed the identified reasons for the use of these care pathways over a specific period of time and reviewed the impact of improvement plans implemented to reduce hospital admissions. Improvement plans included patient education in relation to available community services such as gynaecology, and maintenance of registers for people with long term conditions.

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 had arrangements in place to respond to the needs of patients aged 75 and over.

Older people we spoke with and comment cards received showed people were cared for with dignity and respect and they were happy with the care provided. The provider worked with multi-disciplinary professionals and community services to ensure older people received appropriate assessment, planning and delivery of care within their own homes and care homes. Physical health checks and health promotion advice was also provided to patients.

Staff we spoke with demonstrated an awareness of involving older people and their next of kin and / or carer in making decisions about their care and treatment.

People with long-term conditions

The practice had arrangements in place to meet the needs of this population group.

Regular clinics and patient care reviews were held with other multi-disciplinary professionals to ensure patients with long term conditions received coordinated care. Appropriate referrals to community services for specific diagnosis such as diabetes, musculoskeletal conditions and dementia were made. Some areas required improvement including involvement with the palliative care team for patients receiving end of life treatment.

Mothers, babies, children and young people

The practice had arrangements in place to meet this population group.

Most of the patients we spoke with and comment cards received showed that patients were satisfied with the nursing and midwifery care provided, and felt the service was caring and responsive. There were appropriate arrangements in place to safeguard mothers, babies, children and young people from abuse and ensure they received immunisations, antenatal and postnatal checks in line with national guidance. Medicines such as vaccinations and immunisations were effectively managed.

Information relating to external support groups and community services provided for this population group were displayed on the communal noticeboards and available for patients to access.

Summary of findings

The working-age population and those recently retired

The practice had arrangements in place to respond to this population group.

Feedback received from patients was mostly positive about the way staff treated them and the care received. However, some patients felt improvements were required to the appointment booking system to reduce the waiting period for non–urgent appointments and for clinic times to be varied and include access outside working hours.

The provider had effective systems in place for the safe management of medicines and joint working processes with multi-disciplinary professionals within primary and secondary care services. This ensured appropriate referrals, treatment and care were provided for working age people with long term conditions.

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

The practice had arrangements in place to meet the needs of this population group.

The practice maintained a register for people with learning disabilities as a source of information to inform the monitoring of their care needs. Clinical staff we spoke with told us annual health checks and care planning for people with learning disabilities were undertaken with their carers and / or next of kin.

Staff we spoke with demonstrated awareness of the provider's safeguarding policies and knew what action to take if they needed to raise an alert.

People experiencing a mental health problems

The practice had arrangements in place to meet the needs of this population group.

The practice had arrangements in place to provide effective and coordinated care in liaison with community mental health professionals. A register for patients with mental health needs was maintained to inform the regular monitoring of their health needs, and ensure people were contacted and recalled to the practice when appropriate.

The GP practice provided care services to people with mental health needs living in local supported accommodation and care homes. Staff that we spoke with had an awareness of the Mental Capacity Act 2005 and Mental Health Act 1983, and implications for consent to treatment.

People experiencing poor mental health

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

Summary of findings

The practice had arrangements in place to meet the needs of this population group.

The practice had arrangements in place to provide effective and coordinated care in liaison with community mental health professionals. A register for patients with mental health needs was maintained to inform the regular monitoring of their health needs, and ensure people were contacted and recalled to the practice when appropriate.

The GP practice provided care services to people with mental health needs living in local supported accommodation and care homes. Staff that we spoke with had an awareness of the Mental Capacity Act 2005 and Mental Health Act 1983, and implications for consent to treatment.

Our findings

Practice meeting minutes and records we looked at showed the provider worked in liaison with multi-disciplinary mental health professionals and community services to ensure positive outcomes for people experiencing poor mental health. For example, GPs referred some patients to the community crisis team to prevent a mental health relapse and / or offered hospital admission where appropriate.

One GP told us with the consent of individual person's, they made referrals to the local Improving Access to Psychological Therapies (IAPT) service, which provided treatment programmes such as one to one therapy, counselling and group work to support people suffering with depression, anxiety and related problems. However one mother told us they had to resort to private counselling for their child due to not being signposted to appropriate NHS mental health services. The GPs also provided care to older people with a diagnosis of dementia and younger adults with severe mental health needs.

The provider maintained a register for patients experiencing poor mental health needs. Staff told us this register informed the monitoring and regular review of patients' physical health checks, blood tests, medicines and treatment plans where appropriate.

Staff we spoke with were aware of the need to safeguard vulnerable people from abuse and the requirements under the Mental Capacity Act 2005 and Mental Health Act 1983. Where an individual could not provide consent, staff told us best interest decisions were made with input from professionals involved in the patient's care and their next of kin.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10(1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010 - Assessing and monitoring the quality of service provision. People were not always protected against the risks of inappropriate or unsafe care by means of effective systems to regularly assess and monitor the quality of the service. For example, there was a lack of up to date and completed cycles of clinical audits relating to all the population groups, analysis of some significant incidents had not been fully completed on the provider's related forms and a legionella risk assessment had not been completed following a building survey undertaken in February 2013.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20(1)(b)(i)(ii)(2)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010 – Records. People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information relating to person's employed by the service and management records related to the regulated activities. This included retention of staff personnel records onsite, practice meeting minutes and clinical audits.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21(a)(i)(ii)(iii) HSCA 2008 (Regulated Activities) Regulations 2010 - Requirements relating to workers.

This section is primarily information for the provider

Compliance actions

The provider did not operate effective recruitment procedures to ensure that information specified in Schedule 3 and such other information as is appropriate, was available in respect of staff employed by the service.