JS Medical 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.

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 JS Medical Practice on 15 September 2015. Overall the practice is rated as good.

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.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- 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.

However, there were areas of practice where the provider needs to make improvements.

The provider should:

- Develop a full business continuity plan.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice had systems in place to ensure patients were safe including safeguarding and chaperone procedures, and processes to ensure medicines were correctly handled. Patients were treated in a clean environment and processes were in place to monitor infection control. Equipment was fit for purpose and maintained regularly.

Are services effective?

Good

The practice is rated good for providing effective services Staff referred to guidance from the National institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff received training appropriate to their roles and there was evidence of appraisals and development plans for all staff. Staff worked closely with multidisciplinary teams and carried out advanced care plans.

Data showed patient outcomes recorded in the Quality and Outcomes Framework (QOF) were below the Clinical Commissioning Group averages for the locality. The practice was aware and had a plan in place to improve these figures.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. For example, in the GP Patient survey 2014, 86% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that 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. The practice had interpreting facilities for consultations. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated good for being well-led. It had a clear vision and strategy which all staff were aware of and knew their responsibilities in relation to this. The practice had numerous policies and procedures to govern activity and regular staff meetings were held where governance was discussed. There was a system in place to identify risk and monitor and improve quality. The practice was proactive in obtaining feedback from staff and patients, which it acted on. Staff had inductions, regular appraisals and regular meetings and events were attended.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked with a local care of the elderly consultant and palliative care team to help manage the older people within their own homes. The practice was involved in monthly teleconferences with the local hospital to discuss frequent admissions and how care could be optimised within the practice.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. For example, the vaccinations given to under two year olds ranged from 97.5% to 100%, compared to the Clinical Commissioning Group (CCG) average range of 76% to 100%. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Evening extended hours appointments were available. The practice was proactive in offering online services, including registering online, booking appointments, ordering prescriptions and accessing medical summaries. The practice had a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for 50% of patients with a learning disability and was working towards improving the figure. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in 2014 showed the practice was performing in line with local and national averages. There were 425 surveys sent to patients with 99 responses which represents 22% of the patient population.

- 87% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 86% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 90%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 33 comment cards which were all positive about the standard of care received. Patients were happy with the service provided by the practice and felt included in their treatment decisions.

Areas for improvement

Action the service SHOULD take to improve

- Develop a full business continuity plan.

JS Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. It included a second CQC inspector, a GP specialist advisor and a practice manager specialist advisor who was granted the same authority to enter the JS Medical Practice as the Care Quality Commission (CQC) inspector.

Background to JS Medical Practice

JS Medical Practice (Philip Lane Branch) is a practice located in the London Borough of Haringey. The practice is part of the NHS Haringey Clinical Commissioning Group (CCG) which is made up of 51 practices. It currently holds a Personal Medical Service (PMS) contract. The practice has recently taken on a failing practice at the request of NHS England which has become a branch surgery of JS Medical (Park Lane Branch). Both practices provide a combined NHS services to 7400 patients.

The practice serves a diverse population with many patients attending where English is not their first language. The practice has a predominantly younger patient population with 62.8% under the age of 65. JS Medical Practice is situated within a purpose built two storey health centre which it shares with another practice. Consulting rooms are situated on two levels. A lift is available to provide access to the upper floor. The Park Lane branch is located in a converted shop facility. Consultation rooms are on the ground level. There are currently two full time GP partners (one male and one female), four regular sessional GPs (three female and one male), a nurse practitioner, practice nurse, healthcare assistant, administrative staff and a practice manager.

JS Medical Practice (Philip Lane branch) is open and offered appointments between 8.30am and 8.00pm on Monday and Tuesday, 8.30am to 6.30pm on Wednesday and Friday, and 8.30am to 1.30pm on Thursday. Extended hours surgeries are offered on Monday between 6.30pm and 8pm and Tuesday between 6.30pm and 7.30pm. The Park Lane branch surgery is open and offered appointments from 9am to 6pm each week day except for Thursday when the practice closed at 1pm. Extended hours appointments are offered between 6pm and 7.45pm on a Monday. In addition pre-bookable appointments can be booked up to six weeks in advance; urgent appointments are also available for people that needed them. Patients are able to book appointments on-line. The practice opted out of providing an out of hours service and refers patients to the local out of hours service or the '111' service.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and the treatment of disease, disorder or injury.

The practice provides a range of services including child health and immunisation, minor illness clinic, smoking cessation clinics and clinics for patients with long term conditions. The practice also provides health advice and blood pressure monitoring.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014. Neither branch of JS Medical had been previously inspected.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- 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 with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 September 2015. During our visit we spoke with a range of staff (GPs, nursing staff and administrative staff) and spoke with patients who used the service. We observed how people were being cared for and talked with patients and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. We inspected both the Philip Lane and Park Lane branches.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach with a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the GP or practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of clinical meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we saw evidence of action taken as a result of an incident where medicines were prescribed in error following a repeat prescription being presented by a patient from their former GP without being assessed at the practice. Further checks were put in place at reception and the policy was changed so that a GP reviewed all medicines issued to new patients.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. Safety alerts were disseminated to relevant staff via email.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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. There was a GP lead for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. When required, the safeguarding lead represented the practice in quarterly meetings with the local social services team to discuss safeguarding matters and individual patients of concern. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that chaperones were available, if required. Reception staff acted as chaperones and were trained for the role. All had received a disclosure and barring service check (DBS). (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).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments, regular fire drills were carried out and the fire alarms were tested on a weekly basis. Fire equipment servicing was overdue and was last serviced in September 2014. We were provided with evidence that the practice had the tests booked for the end of September 2015. Electrical equipment was checked in December 2014 to ensure the equipment was safe to use. Clinical equipment had also been checked and calibrated in December 2014. The practice also had a variety of other risk assessments in place to monitor the safety of the premises such as Control of Substances Hazardous to Health (COSHH) and infection control. We saw evidence of a current legionella (a germ that is found within water systems) test dated August 2015. Some issues were identified in the assessment that the practice were working to rectify, for example ensuring there was an up to date log of water temperatures.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice had up to date cleaning schedules that identified the cleaning on a daily and monthly basis. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. The lead had received the appropriate level of training to undertake this role. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and the last audit was completed within the last 12 months.

Good

Are services safe?

- The arrangements for managing medicines, including vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Two members of staff were assigned to maintaining the stock of medicines in line with the practice policy and procedure. We checked the medicine fridges and found all medicines to be in date. All temperature monitoring charts were up to date and all were in the appropriate range. Regular medicines audits were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Patients who were prescribed high risk medicines such as disease-modifying anti-rheumatic drugs (DMARDs) were reviewed regularly by the GP. Prescription pads were stored in a lockable cabinet in reception. Prescription scripts (FP10s) were logged in and out by serial number. Recruitment checks were carried out and the 10 files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS) for clinical staff. DBS checks were carried out for all members of staff and the practice reviewed them every three years.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty which was monitored by the practice manager. If the practice was short staffed, overtime was offered to staff or locum staff would be employed.

Arrangements to deal with emergencies and major incidents

There was an alert button on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Both were maintained on an annual basis and checked on a monthly basis. There was also a first aid kit and accident book 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 fit for use

The practice had a business continuity management policy in place which outlined how the practice would identify and manage risk such as financial, organisational and environmental, and the business continuity planning framework that it would use. However there was no comprehensive business continuity plan in place which outlined what would be done if a major incident occurred or contact details for staff or the major suppliers to the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment and consent

GPs and nursing staff we spoke with demonstrated a clear rationale for their approaches to treatment. The practice carried out assessments and treatments in accordance with the National Institute of Health and Care Excellence (NICE). Best practice guidelines from the local Clinical Commissioning Group (CCG) was readily available to all staff via the intranet and was also followed. We saw examples of NICE guidance embedded into chronic disease templates and there was a system to ensure that these were kept up to date.

Staff described how they carried out comprehensive assessments, which covered all health needs and was in line with national and local guidance. We were shown the practice chronic disease templates and care plans, which they edited to incorporate discussions, outcomes and actions of multidisciplinary meetings (MDT). This enabled all information about patients to be held in one place and not be missed. They explained how care was planned to meet identified needs and was reviewed at required intervals to ensure that treatment remained effective. For examples, patients with diabetes had regular health checks, which increased if they were unstable and were referred to services when necessary. Feedback from patients confirmed that they were referred to hospital services when required.

The GPs told us that they led in specialist clinical areas such as diabetes and were supported by the nurses to do this work, which allowed the practice the time and resource to focus on specific conditions. Staff told us that they felt supported and advice and support was given when asked for.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The latest results showed that 83% of the total number of points available was achieved, with 7.3% exception reporting. This was below the Clinical Commissioning Group (CCG) average of 90.8%. This practice was not an outlier for any QOF (or other national) clinical targets. The practice was aware of the low figure and stated that a contributing factor was the merger of the branch surgery which was a poor performer, bringing the overall results down. Further data showed;

- Performance for chronic kidney disease related indicators was higher than the CCG average of 90.2% and national average of 86.5% attaining 90.6%.
- Performance for asthma related indicators was higher than the CCG average of 95.2% and national average of 86.5% attaining 97.4%.
- The dementia diagnosis rate was above the CCG average of 93.8% and national average of 94.5% attaining 100%.

The practice showed us two completed audit cycles carried out in the last two years, they were able to demonstrate changes resulting from the initial audits and the impact that this had on their patients, for example their demand and capacity audit led to an increase in advance access appointments, and patients we spoke with told us there was a noticeable difference in appointment availability. The audit on two week wait referrals led to the practice ensuring that 100% of cancer referrals were followed up so all patients were seen within the two week wait appointment system. We also saw minutes where these changes had been made and discussed. The practice also provided an audit to ensure appropriate prescribing of high dose inhaled corticosteroids which are used in the management of asthma. The audit showed through a review of asthma patients that not all read codes were being documented in patient records. A review of all 32 patients on the asthma register were called in for a review and more proactive monitoring was put in place. The audit was due for review in October 2015.

The GPs told us that they carried out clinical audits of medicines management information and as a result of QOF. For example, we saw an audit of antibiotic prescribing, which picked up that a locum was an outlier in their prescribing of antibiotics; we saw an antibiotic prescribing policy that was devised as a result of this.

The practice undertook the unplanned admissions direct enhanced service (DES), Accident and Emergency (A&E) attendance and discharge was coded on their clinical system. All patients discharged from hospital were contacted by the GP within three days via telephone and using their discharge notification, discussions were had

Good

Are services effective?

(for example, treatment is effective)

with the patient giving them information such as any medicines they may have been started on and they were invited in for an appointment if necessary. We saw a quarterly audit report of A&E attendances and actions that were required. .

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date with attending mandatory courses such as basic life support. There was a good skill mix among the doctors with one of the partners having an additional diploma in practical dermatology. Both partners demonstrated active roles in the CCG which enabled them to use this knowledge to provide a greater service to patients. All GPs were up to date with their yearly continuing professional development requirements and had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertake a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All staff had annual appraisals where learning needs were identified and action plans were put into place and documented. Interviews with staff confirmed that the practice were proactive in providing training and support to staff, the practice advanced nurse practitioner spoke of being supported to gain her advanced qualification and reception staff told us that they were given areas to lead on, for example a receptionist had also been trained to be a smoking cessation advisor and another to be a health care assistant.

The practice had an induction programme for new staff and consisted of training topics such as health and safety, fire safety and safeguarding.

Working with colleagues and other services

The practice worked closely with other service providers to manage patients with complex health requirements and to meet patient's needs. Discharge summaries, blood test results, x ray results from local hospitals as well as out of hours GP service patient summaries and '111' patient information was received electronically. We saw a policy for acting on electronic information which outlined the passing on of the information and the time at which doctors had to act on notifications, which was same day for urgent actions. All staff understood their role, there were no significant events relating to this process in the past 12 months, and we saw that the practice was up to date to with the actioning of these alerts.

The practice held a number of different multidisciplinary (MDT) meetings for example:

- MDT meetings with the community matron and district nurses were held every 6-8 weeks.
- MDT meetings with the health visitor were held every 6-8 weeks
- MDT teleconferences took place every 4 weeks with North Middlesex hospital to discuss patients aged over 65 who had attended A&E more than twice in the previous 6 month period.
- MDT with a psychiatrist to discuss complex cases every 4 weeks.

We saw minutes of these meetings and viewed patient records which showed that MDT patient summaries and outcomes were entered into the patient record and where appropriate outcomes were incorporated into the patients care plans.

Information sharing

The practice used an electronic system to communicate with other providers; the majority of results and discharge summaries were received electronically and were assigned to a clinician to action and filed into the patient record. There was a scanning system for results and discharge summaries that were received by post or fax that would put the information directly into the patient record and go to the GP for actioning.

There was an information sharing policy, all non-clinical staff demonstrated an awareness of this and there were posters in the admin areas reminding staff of what information could be shared and with whom.

Consent to care and treatment

We found that staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA); we saw that both GP partners were booked to attend MCA and Deprivation of liberty and safeguarding training (DOLs). All clinical staff we spoke with understood the key elements of the legislation and described how they would support patients in decision making about their care and treatment.

Good

Are services effective?

(for example, treatment is effective)

Patients with learning disabilities and those with dementia were supported alongside their carers to make decisions through the use of care plans, which they were involved in agreeing, end of life wishes were documented and communicated with the community teams. The GP's had motivational interviewing training, which enabled them to work with patients to set goals and incorporate these into the care plans.

Care plans were reviewed annually or more often if there was the clinical need, we saw that summaries from MDT meetings were added to care plans when appropriate. All clinical staff demonstrated a clear understanding of patient's best interest and Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and understand the implications of those decisions).

The practice had a consent policy, all staff were aware of when to obtain consent. Verbal consent was recorded in the patient's notes for minor procedures; we saw examples of written consent to allow information to be shared with a family member.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the borough needs assessment as well as the Joint strategic needs assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients including children. The GP was informed of all health concerns detected and followed up in a timely way. The practice used new patient health checks as a means to offer lifestyle advice and screening such as cytology screening and chlamydia checks. The practice also offered NHS Health checks to all patients aged 40 to 75 years. However the practice had only recorded a 12% uptake. The practice also offered new patient registration health checks and recorded an uptake of 76%. Fifty percent of patients on the learning disability register had received a health check. The practice were working to improve this service by publicising this service within consultations.

Childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.7% to 100% (Clinical Commissioning Group (CCG) comparison range 76% to 100%) and five year olds from 86.3% to 96.1% (CCG Comparison range 84% to 91.6%). Flu vaccination rates for the over 65s were 73%, and all pregnant women 39.5%. There was no comparable flu vaccination data available from the CCG.

The practice had many ways of identifying patients who needed extra support, for example the practice had a 70% smoking quit rate, which they increased by training a smoking cessation advisor and proactively offering smoking cessation appointments and a system for following up appointments with telephone calls.

The practice performance for the cervical screening programme was 80% which was comparable to the national average of 81%. The practice employed a cytology coordinator who invited patients to have their cytology screening and followed up patients who did not attend, patients were also telephoned with an appointment reminder. There was a policy in place to recall patients who had an inadequate test and for patients who required further testing.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so, when closed, patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 33 patient CQC 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 also spoke with two members of the patient participation group (PPG) on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice scored above the Clinical Commissioning Group (CCG) average for its satisfaction scores on consultations with doctors and nurses. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 86% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%
- 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 85%.
- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 90%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and 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 on the comment cards we received was also positive and aligned with these views.

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

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 81%.

Staff told us that translation and interpreting 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.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and those identified on the register were being supported, for example, by offering health checks, flu vaccinations and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area Services were planned and delivered to take into account the needs of different patient groups and to help provide and ensure flexibility, choice and continuity of care. For example;

- There were longer appointments available for older people and those patients with a learning disability.
- Home visits were available for patients who would benefit from these.
- Named GP for older patients and those on the learning disability and mental health registers.
- Monthly teleconference meetings with the local hospital to discuss frequent admissions for patients over the age of 65 to optimise their care at the practice.
- Joint working with the community matron and chronic disease nurse specialists.
- Multi-disciplinary team meetings were regularly undertaken with the palliative care team and care of the elderly consultant to help manage older people in their own home.
- Proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care
- The practice provided an out of hour's service for the care homes to contact GPs out of hours in the event of the death of a resident in order to be sensitive to cultural needs.
- Urgent access appointments were available for children and patients with serious medical conditions, including those patients involved with the local mental health crisis team.
- The practice provided a full sexual health and contraception service.
- The practice provides a full post and antenatal service. Including proactive referrals for under 5s to health visitors for vulnerable families. The practice also undertook joint working with school nurses, health visitors and midwives.
- Transitional care support for patients turning 18 that need adult services, for example patients with sickle cell, congenital conditions, diabetes, asthma and children in care.
- Patients were able to register online, book appointments, order prescriptions and see their medical summary.
- An extended hour's clinic was held by a GP and nurse for two days a week.
- There were disabled facilities, hearing loop and in-house translation services available.
- The practice, along with four other practices, provided a daily telephone consultation service between 8.30am and 6.30pm which enabled patients of the practices to always have telephone access to a GP.

Access to the service

The main practice (Philip Lane Branch) was open and offered appointments between 8.30am and 8.00pm on Monday and Tuesday, 8.30am to 6.30pm on Wednesday and Friday, and, 8.30am to 1.30pm on Thursday. Extended hours surgeries were offered on Monday between 6.30pm and 8pm and Tuesday between 6.30pm and 7.30pm. The Park Lane branch surgery was open and offered appointments from 9am to 6pm each week day except for Thursday when the practice closed at 1pm. Extended hours appointments were offered between 6pm and 7.45pm on a Monday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Patients were able to book appointments on-line. Following feedback from patients the practice planned to provide a full service on a Thursday afternoon from November 2015.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to or above local and national averages; and people we spoke with on the day were able to get appointments when they needed them. For example:

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 70% and national average of 55%.
- 78% patients said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 73%.
- 72% patients described their experience of making an appointment as good compared to the CCG average of 68% and national average of 73%.
- 78% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 51% and national average of 58%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place 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 the practice leaflet contained information to help patients understand the complaints system within. Posters were also on display throughout the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at the 3 recorded complaints received in the last 12 months (the practice recorded all written and verbal complaints) and found these were satisfactorily handled and dealt with in a timely way. The responses demonstrated openness and transparency in dealing with the complaint.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, after a patient complained that there was a delay in their telephone consultation, the practice sent a letter of apology and changed the practice policy to offer telephone consultations in time slots rather than at specific times. This enabled the practice to take account of longer running calls.

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. We saw minutes of an externally facilitated practice staff away day in 2014 where the practice values were agreed. We saw the strategy and five year business plan that was regularly updated and all staff that we spoke with was aware of this plan. The practice values included being patient centred with a no blame culture.

Governance arrangements

The practice had numerous policies and procedures in place to govern activity and these were all available on the shared drive, which was accessible from any computer in the practice. We looked at two policies and they were up to date and the practice could evidence that they were reviewed annually.

A clear leadership structure was in place with named members of staff in lead roles. For example there was a GP partner lead for safeguarding and a nurse lead for infection control, we spoke with three non-clinical staff members who confirmed who the leads were and the leads clearly outlined their roles and responsibilities. All staff told us that they felt valued and knew who to go to if they had a concern.

The practice had a GP organisational lead and a GP clinical lead, both of which played an active role in overseeing that systems were in place to monitor the quality of the service and ensuring that it was effective. This included the use of the Quality and Outcomes Framework (QOF) which is a voluntary incentive scheme that financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The QOF data for this practice was generally in line with national standards and we saw evidence that that QOF performance was regularly discussed at practice meeting with action plans to improve outcomes.

The practice had an on-going programme of clinical audits, which it used to bring improvements to the quality of care. For example data from significant events was used to identify areas where improvements could be made. There were processes in place to review patient satisfaction and that action had been taken where appropriate and in response to patient and staff feedback.

The practice identified, recorded and managed risks. The practice carried out risk assessments jointly with the practice that it shares the building with. We saw a completed fire risk assessment along with a legionella risk assessment done in August 2015 where several issues were highlighted and action plans were in place, which included disconnecting the water tank in the loft and installing a new water storage system. We were told that any changes were disseminated by the practice manager.

The practice held monthly staff meetings. We looked at a sample of minutes of the meetings and saw that governance issues, performance, quality and risks were discussed.

The practice manager had responsibility for human resources policies and procedures. We reviewed a number of policies, for example induction policy, recruitment policy and disciplinary procedures, which were in place to support staff. We spoke with staff who were all aware of where to find these policies. The practice also had a whistleblowing policy which was also accessible from all computers in the practice.

Leadership, openness and transparency

Staff told us that the two GP partners were approachable, caring and took the time to listen to them. All staff were involved in discussions about how to run and develop the practice. The partners encouraged members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every four weeks. Staff told us that there was a friendly atmosphere with an open no blame culture, and they were encouraged to discuss issues and felt supported at meetings if they did.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from a number of different sources including the patient participation group

Are services well-led?

Good

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

(PPG), surveys and complaints. We saw evidence that as a result of a patient MORI poll the practice is due to stop closing at 13:30hrs on a Thursday and remained open until 18:30hrs to provide increased access from November 2015.

We also saw evidence that the practice had reviewed its results from the national GP survey to see where any areas that needed addressing. This, alongside practice complaints that highlighted that one of the partner's appointments always ran late led to the practice giving that partner 15 minute appointments instead of 10 minutes, which they reported led to an increased patient satisfaction.

The practice gathered feedback from members of staff through appraisals, away days and practice meetings. Staff told us that they would not hesitate to raise concerns or make suggestions to management. We were given the example of a suggestion being made around the need for an HCA which led to a receptionist being trained to carry out this role.

Continuous improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. All staff files showed that annual appraisals took place, which included development plans. Clinical staff told us that they were given study days and the advanced nurse practitioner told us that she was supported by the partners to progress from a nurse practitioner to an advanced practitioner, whilst being supported to take up an active role in the CCG.

The practice worked alongside the Prince's Trust charity to develop a supporting carer's guide for GPs and also developed a video used for medical students on communication skills.-

The GP partners and the advanced nurse practitioner all had active roles in the Clinical Commissioning Group (CCG). As part of this the practice introduced a service where alongside a group of four other practices, all patients that registered with a practice in the south east of Haringey were able to have a telephone consultation with a GP from one of the five practices between the hours of 08:30 and 6.30pm. Systems were set up to allow the GPs access to the patient notes and consultation summaries were sent to the patient's practice within 24 hours. This service had a good patient satisfaction rating from surveys done with patients who used the service.