Forest Road Group 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

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Summary of findings

Overall summary

Forest Road Group Practice is a single site, five partner training practice that caters for over 12200 patients living in the London borough of Enfield. The percentage of older people affected by income deprivation is higher in Enfield than the England average. The practice organises several clinics for the management of chronic diseases such as asthma and diabetes. They offer a variety of other medical services including antenatal and postnatal care, minor surgery, childhood vaccinations and well-person check-ups.

On the day of our visit we spoke to staff, patients and their relatives. Prior to our inspection we spoke to other professionals involved in delivering integrated care such as care home managers, palliative care, safeguarding lead nurse, health visitors and pharmacy. We also collected patient views through comments cards that were left at the practice two weeks prior to the inspection.

As part of the inspection we looked at all the regulated activities provided by the service which are diagnostic and screening, family planning, maternity and midwifery, surgical procedures, and treatment of disease, disorder or injury. The practice provided some minor surgery and had adequate infection control provisions to support these.

The practice provided a safe service for all population groups with regard to medicine management and dealing with emergencies. However, the practice did not always ensure that people were cared for in a clean and hygienic environment because the chairs in the waiting room and consulting rooms were made of cloth and could not be cleaned properly.

There were effective systems in place to ensure that staff followed appropriate guidance. Joint working with other healthcare professionals was facilitated by regular integrated acre meetings. There was a training and appraisal schedule for both clinical and non clinical staff.

The practice was caring. Patients were treated with dignity and respect. The practice made provisions for end of life care and bereavement support where needed. Staff were described by patients as caring and we observed reception staff and clinical staff speaking to patients in a pleasant manner. Doors were closed during consultation and reception staff spoke in soft voice tone to prevent other patients from overhearing. There was also a separate room that could be used to talk to patients.

The practice was responsive to the needs of the population it served. There was provision for speakers of languages other than English where required and extra time was allocated to appointments where translation was required, in order to provide comprehensive treatment.

The practice was well led. There were clear governance structures. Staff were supported to develop and progress within their roles. Both clinical and non clinical staff felt that the managers were approachable and that there was an open and transparent culture.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was providing a safe service for all population groups. Medicines were checked and stored appropriately. Infection control procedures were followed and regular infection control audits were completed. Action was taken following audits in order to minimise the risk of infection to patients. Staff had undergone relevant recruitment checks such as disclosure and barring checks to ensure they had no restrictions that prevented them from working with vulnerable adults or children. There were appropriate recruitment checks in place to ensure that patients were cared for by competent staff who had undergone disclosure and barring checks. Clinical staff had appropriate health checks such as hepatitis B immunisation.

However, the practice did not always ensure that people were cared for in a clean and hygienic environment because the chairs in the waiting room and consulting rooms were made of cloth and could not be cleaned properly. This could cause the spread of infection.

Are services effective?

There were effective systems in place to ensure that staff followed appropriate local and national guidance. Care was assessed and planned to ensure that it was delivered in line with the National Institute for Health and Care Excellence (NICE) guidelines. There was a training and appraisal schedule for both clinical and non clinical staff. Procedures were in place to ensure that equipment was serviced, cleaned and maintained according to manufactures guidance.

Leaflets were offered to patients in order to enable them to manage their current health conditions and the service ran several health promotion clinics such as smoking cessation and obesity. There were clinics and leaflets for people with long term conditions such as asthma and diabetes which were available in the waiting area and consulting rooms.

Are services caring?

Patients were treated with dignity and respect. Staff were described by patients as caring and we observed reception and clinical staff speaking to patients in a pleasant manner. Doors were closed during consultation and reception staff spoke in soft voice tone to prevent other patients from overhearing. There was also a separate room that could be used to talk to patients. The practice made provisions for end of life care and bereavement support where needed.

Summary of findings

Are services responsive to people's needs?

The practice was responsive to the needs of the population it served. There was provision for speakers of languages other than English where required and extra time was allocated to appointments where translation was required, in order to provide comprehensive treatment. Comments and complaints were dealt with in a timely manner and there was evidence that the practice listened to patients, including the views of the Patient Participation Group (PPG).

Are services well-led?

Forest Road Group Practice had a well led service where provision was made to ensure that staff adhered to the practice's vision and values and treated people as individuals, regardless of their age, culture condition or background. Both clinical and non clinical staff felt that the managers were approachable and that there was an open and transparent culture. Staff told us they were aware of the whistleblowing process and could raise concerns with their managers. Staff were supported to develop and progress within their roles.

There were systems in place to ensure, regular clinical audits were completed, staff received appropriate training and support and ensure that all equipment and the premises were maintained in order to minimise the risk to patients.

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

Forest Road Group Practice provided a safe service for older people in their home, at the practice and in a care home setting. The practice currently had 578 older people on their list which all have a named GP on file. It has various health promotion clinics and an on-call service which provided home visits. The practice worked closely with two care homes in the locality responding promptly when called out to review people living at the homes. Older people were assessed in a timely manner regardless of their setting. Staff had training on safeguarding vulnerable adults and said they would report concerns to the safeguarding lead. Regular medications reviews were conducted where applicable in order to ensure that patients were taking medication relevant to their current health needs.

We observed that staff were caring and treated patients with dignity and respect. The surgery was responsive to the needs of older people. Flu jabs vaccinations campaigns were in place and over 75s had a named doctor responsible for their care.

People with long-term conditions

Forest Road Group Practice provided a safe service for patients with long term conditions such as asthma, diabetes, chronic kidney disease and hypertension. The practice currently had 3927 people classified as having one or more long term conditions. Long term conditions were catered for effectively by ensuring that staff were responsible for specific long term conditions. They ensured that any updates or change to guidelines were shared with all relevant staff.

There were effective systems in place to ensure staff followed relevant clinical guidelines to manage a range of long term conditions. NICE guidelines were used to manage patients with long term conditions. The computer system was used to alert when annual health checks were due and flagged up all the conditions the patient had at each consultation to ensure that opportunistic screening could be completed during routine consultations as well.

Mothers, babies, children and young people

There were effective systems in place to ensure that mothers, babies, children and young patients received appropriate care and treatment. The practice had 3900 patients on its list classified as mothers, children, young people or babies. The practice worked closely with health visitors and midwives and the children's

safeguarding lead. There were immunisation clinics for children, postnatal checks for women and developmental checks services available. We observed that staff were caring and treated people with dignity and respect.

The working-age population and those recently retired

Forest Road Group Practice provided a safe service for working age people and those recently retired. The Practice had 7096 patients on its list classified as working age or recently retired. The practice offered extended opening hours on a Wednesday and Thursday and online appointment booking services to enable the working population to access services. People from this group told us that they found booking appointments online and the late opening hours convenient.

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

The practice provided safe care to vulnerable groups by providing care that did not discriminate but delivered individualised care. There were effective systems in place to ensure vulnerable people such as those with a learning disability were reviewed and supported appropriately. There were systems in place to support carers. Staff were aware of issues relating to capacity to consent and told us that people with learning disability always visited with a carer.

People experiencing poor mental health

The practice had 863 patients on its list with various mental health conditions. The service provided a safe and effective way to manage patients with mental health conditions in accordance with national guidelines. The practice worked with the Enfield Improving Access to Psychological Therapies (IAPT) service. The IAPT work with people aged 16 years or over who are experiencing common mental health problems such as depression, anxiety and stress. Patients at the practice could refer themselves directly or could be referred by their GP, with the patients consent. Forest Road Group Practice had a well led service where provision was made to ensure that people with mental health needs were assessed and referred appropriately to other agencies.

Summary of findings

What people who use the service say

The Department of Health GP Patient Survey completed between January 2013 and September 2013 showed that patients were not happy with the telephone appointment system and the way a member of staff spoke to them. The survey completed by the practice in March 2014 where 170 patients responded also showed that telephone access was a problem.

We collected 10 comment cards where patients told us that they were very happy with the care and treatment they received from doctors and nurses. Their main complaint was that it was difficult to get through on the phone although they could get same day appointments by walking in or by booking an appointment online.

The practice manager told us and we saw evidence that showed plans were in place to change the telephone system. They were waiting for the approved contractor to start work. Clinical staff told us that complaints about staff has ceased after changes to the staff team had been made.

We spoke to 18 patients on the day of our visit. Most said they were very happy with the care and treatment. Others said they would have preferred to see the same doctor. They all said they had been treated with respect and that they had confidence and trust in the doctors and nurses that attended to them. We also spoke to four members of the patient participation group who had all been at the practice for over 19 years and told us that they felt that the patient voice was listened to. They told us and showed us pictures of campaigns they had done at the local festival where practice staff had stalls and offered blood pressure checks to members of the public.

Areas for improvement

Action the service COULD take to improve

Some prescription pads were not kept securely at reception and were at risk of being taken and misused by an unauthorised person.

The current machine used by patients to announce their arrival for an appointment was not working. Patients said that they wanted the machine repaired as their queuing time at reception announcing their arrival, was increasing.

The provider may wish to note that staff were not aware that safeguarding cases needed to be reported to the Care Quality Commission. (CQC).

Good practice

The practice had recently involved its PPG in the recruitment and selection of a new partner. This had been done by hiring an actor to do a role play consultation with the four shortlisted candidates and members of the PPG voting on the best consultation. This demonstrated involvement of the patients in deciding who they wanted to care for them.

The practice had a pharmacist visiting weekly in order to ensure that all issues relating to prescribing were audited and discussed with the prescribing lead. They were regular audits on prescribing including an audit for patients prescribed 10 or more medicines.

Telephone calls were not answered at the main reception. Calls were answered in a separate private office leaving more time for reception staff to attend to patients at the front desk.

There were separate rooms available for isolation or counselling when required.

Staff said the practice encouraged them to learn and develop. They were happy with the training and teaching opportunities available especially the weekly teaching sessions that happened on a Wednesday afternoon.

Forest Road Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector, a CQC pharmacist inspector and a GP specialist advisor. They GP specialist advisor was granted the same authority to enter the Forest Road Group Practice as the CQC inspectors.

Background to Forest Road Group Practice

Forest Road Group Practice is a five partner training practice that provides a range of primary medical services needs for over 12200 patients in Enfield. The practice had four Partner GPs and a fifth partner was due to commence in June 2014, four salaried GPs, a nurse practitioner, a diabetes specialist nurse a practice nurse and 13 reception staff. There was also a practice manager and a practice supervisor.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward by inspecting several practices in the same Clinical Commissioning Group (CCG) area at the same time. This practice had not been inspected before and that was why we included them in this group of inspections.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We reviewed the General Practice Outcome Standards (GPOS) data which cover a range of services provided by general practice and represent a level of care everyone should expect to receive from their GP surgery. We also reviewed General Practice High Level Indicators (GPHLI) a tool developed to provide comparative data used by GPs as a reflective tool for quality improvement purposes. We also examined views from patients from Healthwatch and NHS Choices website.

We carried out an announced visit 28 May 2014. During our visit we spoke with a range of staff including nurses, administrative staff, GPs and the practice manager. We

Detailed findings

spoke with patients who used the service. We observed how patients were being cared for and talked with carers and/or family members. We spoke to 18 patients and four members of the Participation Group (PPG). We reviewed 10 comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

The practice was providing safe service for all population groups in terms of safeguarding people from abuse, medicine management and dealing with emergencies. Medicines were checked and stored appropriately. Infection control procedures were followed and regular infection control audits were completed. Action following the audit was taken in order to minimise the risk of infection to patients. Staff had undergone relevant recruitment checks such as disclosure and barring checks to ensure they had no restrictions that prevented them from working with vulnerable adults or children. There were appropriate recruitment checks in place to ensure that patients were cared for by competent staff who had undergone disclosure and barring checks. Clinical staff had appropriate health checks such as hepatitis B immunisation.

Our findings

Safe patient care

There were several leads amongst clinical staff who were responsible for sharing any learning or updates to clinical practice. These included leads in safeguarding, infection control and smoking cessation as well as a diabetes nurse specialist. Staff described how they assessed and planned for care according to people's different needs.
Administrative staff ran checks to ensure that people requiring cervical smears were sent reminder letters promptly. Similar systems were used for annual health checks for people with diabetes or hypertension where all outstanding tests required for an individual were flagged up on the screen each time the patient came for a consultation.

Learning from incidents

There was an incident reporting system in place. Learning from incidents was discussed at practice and clinical governance meetings. Staff told us about learning that had happened from previous incidents. We reviewed the significant event analysis and found that measures had been put in place to avoid recurrence. These included trying to get the same clinician to review people requiring home visits in order to improve the accuracy of diagnosis for bed bound patients with complex needs.

Safeguarding

Clinical staff had completed safeguarding training for both adults and children at the appropriate levels which were level three safeguarding vulnerable children for all clinicians. Staff needing updates had already been identified and training had been booked. Staff were aware of who the safeguarding lead and deputy leads were at the practice. They told us that they would report any concerns such as neglect or domestic violence. We saw appropriate disclosure and barring checks (DBS) checks for staff had been carried out.

The health visitor attended the practice integrated care meetings and was aware of the children and families where the practice had concerns. The computer system was used to flag up all children and families where child protection concerns were identified. The list was discussed and updated regularly. The safeguarding lead and their deputy

Are services safe?

told us about audits that had been completed and how they shared learning. It may be useful for the provider to note that staff did not mention reporting safeguarding cases to the Care Quality Commission (CQC).

Monitoring safety and responding to risk

The practice had systems to respond to risk such as informing patients about epidemics. Staff were able to tell us about the messages they sent to patients regarding epidemics. They advised them not to come into the surgery with issues such as colds and diarrhoea and vomiting without first asking for advice over the telephone, in order to prevent the spread of infection. Spare rooms were available in the practice should the need to isolate a patient arise.

Medicines management

We looked at the storage of medicines held by the practice and saw that all stock was secure.

The practice kept vaccines which needed storage at a particular temperature to maintain their potency and we saw that fridge temperatures were recorded accurately to provide evidence that the cold chain was maintained. The practice also completed several audits on medicines prescribing including patients prescribed four or more medicines in order to minimise the risk of adverse drug reactions. This also ensured that medicines such as Warfarin, antidepressants, diuretics and non-steroidal anti-inflammatory medicines were reviewed appropriately.

Cleanliness and infection control

There were cleaning schedules in place using the national colour coding scheme for cleaning materials and equipment. Staff wore clean clothes and had name badges and told us that they had access to protective equipment. Clinical staff told us they adhered to single use equipment and told us how they cleaned examination couches and other equipment before use.

Sharps bins were correctly assembled and not overfilled. Staff were aware of the location of spillage kits and the procedure to follow in an emergency.

Staffing and recruitment

There were appropriate recruitment and selection procedures in place for staff, including a comprehensive induction programme which included longer appointment times at the beginning for new GPs. Newly recruited staff told us they felt supported during induction and showed us the induction program they had completed. We saw evidence that two references were kept on file for all staff. Mentoring arrangements for salaried GPs and trainee GP were in place.

Dealing with Emergencies

There were procedures in place to deal with medical emergencies including regular checks on the medication oxygen and equipment to ensure that no medicine had expired and that the equipment was working. Staff had up to date Cardio Pulmonary resuscitation (CPR) training which was updated annually and knew where to locate the emergency medication, oxygen and defibrillator in an emergency. Staff were aware of the business continuity plan and there were four mobile phones to be used should the telephone system fail.

Equipment

There were procedures in place to ensure that all equipment was calibrated yearly. Staff were aware of the different reporting systems in place for faulty equipment. There were protocols for cleaning all clinical equipment and staff were aware of single use items. We saw records that showed that buildings and equipment were maintained appropriately and that health and safety checks had been completed.

Are services effective?

(for example, treatment is effective)

Summary of findings

There were effective systems in place to ensure that staff followed appropriate guidance. Care was assessed and planned to ensure that it was delivered in line with NICE guidelines. Clinical audit cycles were completed.

Patient's needs were met by staff who were appropriately qualified and had regular appraisals. There were procedures in place to ensure that equipment was serviced, cleaned and maintained according to manufactures guidance.

There were several health promotion clinics and leaflets available for long term conditions such as asthma, diabetes and smoking cessation to enable patients to manage their current health conditions and prevent conditions such as obesity from developing.

Our findings

Promoting best practice

Patients were cared for in a practice that held regular practice, integrated primary care team and clinical governance meetings in order to ensure that information on any updates and changes to clinical practice was shared with all relevant staff. A nurse gave an example of a change to the NICE guideline on the use of statins and how this had been implemented to improve the management of patients with diabetes. . Another example was communicating to patients and clinicians that fasting blood glucose was no longer a requirement. The national gold standards framework (a framework used to train staff to enable them to provide gold standard care to patients nearing the end of their life) was also being used to effectively manage palliative care patients.

Clinical and non clinical staff demonstrated knowledge of the Mental Capacity Act 2005 and how this was used this in practice. Clinical staff were able to give instances of where they had assessed a patient's capacity and told us that they had attended mental capacity training. Specific care plans were made for vulnerable people such as vulnerable children, vulnerable adults and patients with mental health needs.

Management, monitoring and improving outcomes for people

The practice completed audits on clinical care and on appointment waiting times. We saw an example of an ongoing audit on the use of antipsychotic medicines in patients with dementia. The audit targeted as many patients with dementia as possible and aimed to reduce the use of these medicines. Cervical smear results were also monitored and recorded. Opportunistic chlamydia screening (screening prompted by a patient request for a tests or when a clinician randomly offers a test to a patient.) was also offered for sexually active people.

The practice had systems in place for patients to order their repeat prescriptions in a timely manner.

The practice was reviewing the telephone network because of delays experienced by patients and had offered alternative methods of requesting repeat prescriptions such as via the practice's website or a nominated

Are services effective?

(for example, treatment is effective)

pharmacy. We also saw evidence that a safeguarding audit had been completed which flagged child protection issues. Issues had been addressed and a second cycle of the audit was due to start.

Staffing

The practice had five partner GPs and three salaried GP's, three nurses, one health care assistant and 13 reception/ administrative staff. There was also a practice supervisor and a practice manager. Skill mix was based on analyses of patterns of demand. Most staff had been at the practice for a long time and there was low staff turnover. There was a system in place to cover for sickness and absence. If required, locums were rarely used otherwise other staff covered for short term sickness. We reviewed staff training records and found that mandatory training was up to date. Staff said they were supported to attend other courses.

Appraisals were up to date with the exception of nurses who had last been appraised in March 2013 but had appraisals due to be completed by the new nurse consultant. We saw evidence to show that staff were helped to develop their careers. Clinical staff told us that they were up to date with continuing professional development (CPD) requirements and doctors were aware of when their revalidation was due.

Working with other services

The practice had built relationships with local authority safeguarding leads, health visitors, district nurses and the two care homes. We were told discharge letters from patient's visits to hospital and out of hours services were scanned into the practice's patient database and that if the patient's own GP was not available the information was shared with another GP on duty at the practice.

There was a monthly multidisciplinary meeting with the psychogeriatrician, six weekly palliative care meetings and regular meetings with the care home managers. They discussed the needs of patients with mental health needs, palliative care needs and those in a care home setting with long term health conditions.

Health, promotion and prevention

The practice ran a travel clinic and we saw the comprehensive medical questionnaire that patients were given before they gave their consent to have the vaccine. The practice nurses had access to a specialist travel advice service and administered vaccines under an individual protocol which had been verified by a senior partner. All batch numbers of vaccines and expiry dates were recorded on the patient's individual electronic record and also their travel log. Other clinics included diabetes care, well woman clinics, breast awareness advice and healthy eating advice.

Are services caring?

Summary of findings

The service was caring. The practice made provisions for end of life care and bereavement support where needed. Staff were described by patients as caring and we observed reception and clinical staff speaking to patients in a pleasant manner. Doors were closed during consultation and reception staff spoke in soft voice tone to prevent other patients from overhearing. There was also a separate room that could be used to talk to patients. Patients told us that they felt included in their care and treatment. Most patients said they chose whether they wanted to see the same doctor for continuity and that they were always involved in all aspects of their care including medication reviews or about other treatment options such as surgery.

Patients were treated with dignity and respect and arrangements were in place to maintain patient's privacy. The 10 comment cards were all positive about the care and treatment received with the exception of the difficulty in getting through to get an appointment over the phone. Seventeen out of the 18 patients we spoke with were happy.

Our findings

Respect, dignity, compassion and empathy

Patients were treated with dignity and respect. The 10 comment cards were all positive about the care and treatment received with the exception of the difficulty in getting through to get an appointment over the phone. Seventeen out of the 18 patients we spoke with were happy

Staff were described by patients as caring and we observed reception and clinical staff speaking to patients in a pleasant manner. Doors were closed during consultation and reception staff spoke in soft voice tone to prevent other patients from overhearing. There was also a separate room that could be used to talk to patients. Telephone calls were answered in a separate, private office leaving more time for reception staff to attend to patients at the front desk.

Patients told us they could choose to be seen by a doctor of the same gender if they requested. The practice had a balance of male and female doctors, which enabled them to accommodate patients who chose to be seen by a clinician who shared the same gender. They all said they had been treated with respect and that they had confidence and trust in the doctors and nurses that attended to them. We also spoke to four members of the patient participation group who had all been at the practice for over 19 years. They told us that they felt that the patient voice was listened to.

Patients told us that the doctors and nurses were respectful and polite at all times. Some people were upset when they came 10 minutes late or more for their appointments because the practice had a rule that if you are more than 10 minutes late you would miss your appointment slot. Reception staff told us that they had attended training on dealing with and resolving conflict or managing difficult situations.

Staff were aware of the chaperone policy which was displayed in the consulting rooms. The reception staff we spoke to told us that they had received training on chaperoning as part of their induction and could demonstrate their role as a chaperone.

The practice made provisions for end of life care and bereavement support where needed. There was also

Are services caring?

support for carers in the form of finding assistance and further information. If a patient was housebound there was a designated GP available for telephone advice via the appointment system.

Involvement in decisions and consent

The practice maintained a palliative care register which was updated regularly. Patients nearing the end of life were offered an opportunity to discuss their needs and preferences. We were told that patients and their families/ carers on the register were offered support to help them live as actively as possible and with dignity. Identifying and assessing patients in need of palliative care meant that the end of a patient's life was as comfortable as possible.

Clinical and non clinical staff were able to demonstrate how they would cater for people who may be unable to consent to care such as, children, those living with dementia and people with learning disabilities. They told us that the parents or the guardians and consented to immunisations and that advocates were sought for adults who were unable to consent for themselves. For teenagers Gillick competency was used to assess competency to make decisions about care without parental involvement based on the individual teenager's understanding.

Patients told us that they felt included in their care and treatment. Most patients said they chose whether they wanted to see the same doctor for continuity and that they were always involved in all aspects of their care including medication reviews or about other treatment options such as surgery.

The current machine used by patients to announce their arrival for an appointment was not working. Patients said that they wanted the machine repaired as their queuing time at reception announcing their arrival, was increasing.

Approximately 24% of the practice population were non-English speaking. There were leaflets available and posters displayed, but more could be done to make information available in a format that could be understood by people with a learning disability or those who could not read in English.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to the needs of the population it served. There was provision for speakers of other languages by use of interpreters where required and extra time was allocated to appointments where translation was required in order to provide comprehensive treatment. Comments and complaints were dealt with in a timely manner and there was evidence that the practice listened to patients including the views of the Patient Participation Group (PPG).

Our findings

Responding to and meeting people's needs

The Department of Health GP Patient Survey, completed between January 2013 and September 2013, and feedback on the NHS choices website, showed that people were not happy with the telephone appointment system and the way one member of staff spoke to them. The practice manager told us and we saw evidence that there were plans in place to change the telephone system. The practice had taken action in response to issues raised by patients concerning the conduct of a staff member.

Most of the 18 people we spoke with said they were very happy with their care and treatment. Several said they would have preferred to see the same doctor. The patient participation group (PPG) told us and showed us pictures of health promotion campaigns they had done at the local festival where practice staff had stalls and offered blood pressure checks to members of the public.

There was provision for speakers of other languages by use of interpreters where required and extra time was allocated to appointments where translation was required in order to provide comprehensive treatment.

Access to the service

The practice was accessible for wheel chair users and opened until 2000 hours on Wednesday and Thursday in order to accommodate working patients. Appointments could be made in person for the same day or the same week. Appointments were also available over the phone or online up to two weeks in advance. Patients could cancel appointments via text message.

Out of hours access information was available on the website and on patient leaflets. Patients and staff told us that calls to the surgery automatically diverted to the out of hours service once the surgery was closed.

The practice kept a doctor's bag and prescription pad easily accessible for a GP to make an unplanned home visit. We were told that they were in the process of reviewing the security of prescriptions pads kept for this purpose.

Concerns and complaints

Staff were aware of the complaints policy and procedure and the location of complaints leaflets. We were told that complaints were responded to promptly in writing, in accordance with the practice's policy. Verbal complaints

Are services responsive to people's needs?

(for example, to feedback?)

were dealt with instantly and staff told us they would escalate to the practice manager or the practice supervisor when a quick resolution failed. We reviewed complaints made in the last six months and found that these were logged and resolved amicably where possible. The main concerns expressed by patients related to telephone access. It was evident that the practice had reviewed this and was in the process of changing the telephone system.

Patients spoken to on the day and the comment cards we reviewed showed that most patients were happy with the way their complaint was resolved. Most thought the main issues were appointment access, the waiting time once they arrived and that they had to rebook their appointment if they were more than 10 minutes late.

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. Provision was made to ensure that staff adhered to the practice's vision and values and treated patients as individuals, regardless of their age, culture condition or background. Both clinical and non clinical staff felt that the managers were approachable and that there was an open and transparent culture. Staff told us they were aware of the whistleblowing process and could raise concerns with their managers. Staff were supported to develop and progress within their roles.

The practice had a range of mechanisms in place to involve patients and improve their experience. There was an active patient participation group who spoke with us on the day and showed us how they had helped with various campaigns such as a Dementia Awareness event held in 2012 and workshops for patients to be shown how to order repeat prescriptions online in 2013.

Our findings

Leadership and culture

The practice manager had oversight of all aspects of the practice while the practice supervisor managed the administrative staff. Nurses reported to the nurse consultant and there was clinical lead GP. All staff were clear on the management structure and the responsibilities of each of the leads. Staff were aware of the practice's vision which could be found on the website, in patient leaflets and in staff information packs issued when staff were recruited.

Staff and members of the PPG felt that they were treated with dignity and respect and that the management promoted in their behaviour an open and transparent culture.

Governance arrangements

The practice had comprehensive policies and procedures in place to support the safe management of medicines, safeguarding vulnerable adults and children and clinical practice. Staff were aware of who the various leads were and who was responsible for updating the practice policies and completing relevant annual audits. All the policies we reviewed had been updated in 2014 and had a review date. Various audits were in place relating to the use of different medications and some were on a continuous audit cycle in order to improve on areas identified in previous audits.

Systems to monitor and improve quality and improvement

The practice was a member of Urgent Health UK which meant they audited and benchmarked against a range of quality standards. The practice continually audited various areas of clinical practice and medicines usage. The prescribing lead GP worked closely with the CCG and was involved in their monthly clinical governance meeting. One of the GPs had attended a seminar on prescription safety and shared this with the rest of the team at governance meetings. We saw evidence that the practice was due to start an external audit to find out about the death of children due to asthma in order to establish future preventative measures.

Patient experience and involvement

The practice had a range of mechanisms in place to involve patients and improve their experience. There was an active patient participation group who spoke with us on the day

Are services well-led?

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

and showed us how they had helped with various campaigns such as a Dementia Awareness event held in 2012 and workshops for patients to be shown how to order repeat prescriptions online in 2013. The PPG also produced a quarterly newsletter which updated patients on the latest news at the practice. The practice had recently involved its PPG in the recruitment and selection of a new partner. This had been done by hiring an actor to do a role play consultation with the four shortlisted candidates and members of the PPG voting on the best consultation. This demonstrated involvement of the patients in deciding who they wanted to care for them

The appointment system had also been changed as a result of patient feedback in January 2014. The practice had dissolved a clinic where people could just turn up and be seen, at the risk of potential long waiting times, to a booked same day appointment slot system. The practice manager responded to patients who left comments on the NHS choices website in a timely and appropriate manner.

Staff engagement and involvement

Staff told us that the practice was supportive. Managers told us they recognised and supported the work done by staff through by awarding trophies for excellence and through promotion when a position became available.

Staff were aware of the whistle blowing policy and told us that they felt their line manager and all clinical and non clinical leads were approachable. They told us they could raise concerns without fear of reprisal. Staff were able to give us an example of action taken in response to concerns raised.

Learning and improvement

GPs told us that the practice vision was to strive towards providing excellent care to all patients. Future plans were to increase the number of GPs and sustain best practices already in place. One partner had been a member of the Clinical Commissioning Group (CCG) until recently and was currently part of the local medical committee. They informally cascaded any information to the rest of clinicians. The practice nurse consultant was in the process of setting up a local practice nurse forum where best practice could be shared. GPs told us that they received feedback regularly from the clinical leads and thought the leadership was very democratic.

Identification and management of risk

Risks were monitored using the quality and outcomes framework which measured how well the practice was performing in terms of patient experience and clinical organisation. Regular audits were completed and appropriate risk assessments were in place for the premises.

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

Forest Road Group Practice provided a safe service for older patients in their home, at the practice and in a care home setting. The practice currently had 578 older patients on their list who all had a named GP. It had various health promotion clinics and an on- call service which provided home visits. The practice worked closely with two care homes in the locality responding promptly when called out to review patients living at the home. Older patients were assessed in a timely manner regardless of their setting. Staff had training on safeguarding vulnerable adults and said they would report concerns to the safeguarding lead. Regular medicine reviews were conducted where applicable in order to ensure that patients were taking medicines relevant to their current health needs.

Our findings

Forest Road Group Practice provided a safe service for older patients in their home, at the practice and in a care home setting. The practice catered for older patients by providing various health promotion clinics and an on call service that provided home visits. Older patients were assessed in a timely manner regardless of their setting. Staff had training on safeguarding vulnerable adults and said they would report to the safeguarding lead. Regular medications reviews were conducted where applicable in order to ensure that patients were taking medication relevant to their current health needs.

The surgery was responsive to the needs of older patients. Flu jabs vaccinations campaigns were in place and home visits were available when required. The two care homes said the GPs came out quickly to attend to the needs of patients at the care home and that there was a named GP who came weekly. All over 75s had a named doctor or were in the process of being assigned a named doctor.

There were effective systems In place to ensure that older people were given care that met their individual needs. The practice worked closely with two care homes in the locality responding promptly when called out to review people living at the homes. Medications were reviewed appropriately and do not attempt resuscitation (DNAR) decisions in the care homes were also reviewed regularly as well as referral made appropriately to diagnose dementia.

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

Forest Road Group Practice provided a safe service for people with long term conditions such as asthma, diabetes, chronic kidney disease and hypertension. The practice currently had 3927 patients classified as having one or more long term conditions.

There were effective systems in place to ensure staff followed relevant clinical guidelines to manage a range of long term conditions. National Institute for Health and Care Excellence (NICE) guidelines were used to manage patients with long term conditions. The computer system was used to alert when annual health checks were due and flagged up all the conditions the patient had at each consultation to ensure that opportunistic screening could be completed during routine consultations as well.

Our findings

Long term conditions such as asthma, diabetes, chronic kidney disease and hypertension were catered for effectively by ensuring that staff were responsible for specific long term conditions and any updates change to guidelines was shared with all relevant staff.

The surgery was responsive to the needs of patients with long term conditions and offered services such as free blood pressure checks at the local community carnival that occurred every summer. Patients told us that their long term condition was managed appropriately by the doctor and the nurse.

There were effective systems in place to ensure staff followed relevant clinical guidelines to manage a range of long term conditions. NICE guidelines were used to manage patients with long term conditions. The computer system was used to alert when annual health checks were due and flagged up all the conditions the patient had at each consultation to ensure that opportunistic screening could be completed during routine consultations as well.

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

There were effective systems in place to ensure that mothers, babies, children and young patients received appropriate care and treatment. The practice had 3900 patients on its list classified as mothers, children, young people or babies. The practice worked closely with health visitors and midwives and the children's safeguarding lead. There were immunisation clinics for children, postnatal checks for women and developmental checks services available. We observed that staff were caring and treated patients with dignity and respect.

Our findings

The practice had safe and effective services for mothers, babies and young patients and worked closely with health visitors, midwives and the children's safeguarding lead. There were immunisation clinics for children, postnatal checks for women and developmental checks services available. Staff told us and we reviewed minutes that showed that information was shared on issues such as self harm, eating disorders and obesity in young people. Health eating and lifestyle advice was also offered by the nursing team and GPs.

Staff were aware of issues relating to consent to care and treatment for children. Staff told us that although the parent or guardian consented on behalf of the child, they always tried to hear the child's voice as well. The practice had a policy in place that did not allow children to be used as interpreters. The same policy expected clinicians to always try to hear the voice of the child in every consultation by including and seeking a rapport with the child.

There were effective systems in place to ensure that mothers, babies, children and young patients received appropriate care and treatment. There were effective systems in place to send reminders to mothers for their children's' developmental checks and immunisations. There was a system in place to ensure that all young people seen with a Body Mass Index (BMI) of greater than 14 were referred to a dietician. BMI is a screening tool used to identify weight problems.

The surgery was responsive to the needs of a diverse population and staff told us that they had previously completed campaigns to reach the Somali population who usually presented late in pregnancy. We found there was information available for young people and there had been a staff session talking about issues that affected young people such as self harm and eating disorders. The practice had also subscribed to the single point of entry (SPOE) .The SPOE was a multiagency response designed to make it

easier for professionals to access early intervention and support when they had concerns about a child, young person or their family. The SPOE jointly risk assessed referrals and decided which services needed to be involved.

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

Forest Road Group Practice provided a safe service for working age patients and those recently retired. The Practice had 7096 patients on its list classified as working age or recently retired. The practice offered extended opening hours on a Wednesday and Thursday and online appointment booking services to enable the working population to access services. Patients from this group told us that they found booking appointments online and the late opening hours convenient.

Our findings

Forest Road Group Practice provided a safe service for working age people and those recently retired. The practice opened up to 20.00 hours twice a week and had an online appointment booking services to enable the working population to access services at a time that was outside standard working hours.

There were effective systems in place to ensure that people's needs were met. There were a range of clinics available including cervical smears, sexual health advice, contraceptive services and breast awareness advice.

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

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

Summary of findings

The practice provided safe care to vulnerable groups by providing a service that did not discriminate but delivered individualised care. There were effective systems in place to ensure vulnerable patients such as those with a learning disability were reviewed and supported appropriately. We observed that staff were caring and treated patients with dignity and respect. There were systems in place to support carers. Staff were aware of issues relating to capacity to consent and told us that patients with learning disability always visited with a carer.

Our findings

Care was delivered by staff who had been trained on safeguarding vulnerable adults and infection control and prevention. Staff demonstrated how they would deal with issues such as domestic violence and child abuse. They were aware of the needs of patients with learning difficulties and responded appropriately to their needs. There were no specific services for the homeless or travellers.

There were systems in place to support carers. Staff were aware of issues relating to capacity to consent and told us that people with a learning disability always visited with a carer.

There were effective systems in place to ensure vulnerable patients such as those with a learning disability were reviewed and supported appropriately. These included a register of people with a learning disability which was monitored to ensure they were offered an annual health check. We were told that appointment times for people were longer if necessary for those having a learning disability or language barriers.

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 863 patients on its list with various mental health conditions. The service provided a safe and effective way to manage people with mental health conditions in accordance with national guidelines. The practice worked with the Enfield Improving Access to Psychological Therapies (IAPT) service. This service worked with people aged 16 years or over who were experiencing common mental health problems such as depression, anxiety and stress. Patients at the practice could refer themselves directly or could be referred by their GP, with the patients consent. Forest Road Group Practice had a well led service where provision was made to ensure that patients with mental health needs were assessed and referred appropriately to other agencies.

Our findings

Patients with mental health conditions received safe care. The practice worked closely with the IAPT service which held a weekly clinic where people with anxiety, stress or depression could self refer or be referred with their consent by their GP or nurse. This ensured that medications were reviewed appropriately and that referrals were made where more support was identified as being required.

Staff were aware of the needs of patients with mental health conditions and described how they would respond to patients who came in with paranoia, or people who indicated that they needed emotional support.

Forest Road Group Practice had a well led service where provision was made to ensure that patients with mental health needs were assessed and referred appropriately to other agencies. A blood testing service was available within the building, providing a one site stop for all patients. The practice also had leaflets for carers and pointed them to support groups where necessary. There were leaflets available in different languages for carer support and for MIND (a charity that provides advice and support to empower anyone experiencing a mental health problem).