The Woodberry 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 The Woodberry Practice on 10 May 2016. Overall the practice is rated as good.

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

- Risks to patients were assessed and well managed.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- 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. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- To consider how to improve its child immunisation programme for the benefit of that patient population.

Summary of findings

- To carry out regular fire drills to mitigate the risks associated with a fire.
- Review how carers are identified and recorded on the patient record system to ensure information, advice and support is made available to all.
- To arrange for all staff to receive an annual appraisal.

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.

- There was no male chaperone available for male patients.
- The practice did not have an up to date fire risk assessment, nor did it carry out regular fire drills.
- Non-clinical staff had not received infection prevention and control training.
- There was an effective system in place for reporting and recording significant events, and lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from abuse.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff had the skills, knowledge and experience to deliver effective care and treatment. However, not all staff had received an annual appraisal in the last 12 months.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were comparable to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice comparable to others for several aspects of care.
- 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.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The practice had become a base for the local anticoagulation service.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed 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 as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was a governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk, though there were some gaps relating to infection prevention and control and fire safety.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice ran memory screening clinics to identify and support patients with memory problems.

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.
- 96% of patients with diabetes, on the register, had had an influenza immunisation in the preceding 1 August to 31 March, which was comparable to the national average of 94%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 lower than the local average for all standard childhood immunisations.
- 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.

Summary of findings

- 80% of women aged 25-64 notes recorded that a cervical screening test had been performed in the preceding 5 years, compared to a national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.

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.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice offered extended hours clinics until 8.30pm on Tuesdays and 8.45pm on Thursdays to enable working patients to attend outside of working hours.

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.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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.
- The practice supported a charity that worked with deaf people, by providing a room for counselling with a sign language interpreter.

Summary of findings

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).

- 92% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive, agreed care plan documented in their record, in the preceding 12 months, which was comparable to the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients 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.
- There was a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. Two hundred and ninety-six survey forms were distributed and 114 were returned. This represented 1% of the practice's patient list.

- 68% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 73% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 75% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all positive about the standard of care received. Patients were all very satisfied with the service received. Many said the staff and GPs were excellent. Others said that the practice was clean and that the staff were polite and helpful.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice participated in the friends and family test (FFT) (FFT is an anonymised method of asking patients if they would recommend the practice to a friend or family member).ninety-four percent of patients responding to the FFT said they would recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- To consider how to improve its child immunisation programme for the benefit of that patient population.
- To carry out regular fire drills to mitigate the risks associated with a fire.
- Review how carers are identified and recorded on the patient record system to ensure information, advice and support is made available to all.
- To arrange for all staff to receive an annual appraisal.

The Woodberry Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to The Woodberry Practice

The Woodberry Practice provides primary medical services in Enfield to approximately 8400 patients and is one of 49 member practices in the NHS Enfield Clinical Commissioning Group (CCG).

The practice population is in the third least deprived decile in England. The practice population has a lower than average percentage of income deprivation affecting children of 15% compared to a local average of 31% and a national average of 20%. The practice had surveyed the ethnicity of approximately 30% of the practice population and had determined that 86% of patients identified as having white ethnicity, 7% Asian, 5% black and 2% as having mixed or other ethnicity.

The practice operates from a converted residential property with patient facilities on the ground and first floors, the ground floor is wheelchair accessible. There are offices for administrative and management staff on the ground, first and second floors. All floors are accessed via stairs.

The practice operates under a Personal Medical Services (PMS) contract (a contract between NHS England and general practices for delivering personal medical services. This contract allows the flexibility to offer local services within the contract) and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract). The enhanced services it provides are: childhood vaccination and immunisation scheme; extended hours access; alcohol cessation advice; facilitating timely diagnosis and support for people with dementia; influenza and pneumococcal immunisations; learning difficulties; minor surgery; risk profiling and case management; rotavirus and shingles immunisation; and unplanned admissions.

The practice team at the surgery is made up of one full-time male partner, one full-time female partner and two part-time female partners.There are two part-time female salaried GPs. The doctors provide 36 clinical sessions per week. The nursing team consists of two part-time female practice nurses, and a part-time female health care assistant. There are five administrative and clerical staff, a full-time practice manager, and eight reception staff.

The practice is open between 8.00am and 6.30pm Monday to Friday. Appointments are from 9.00am to 12.30pm and 2.00pm to 5.30pm daily, with on-call doctors available from 8.30am to 11.30am and 4.00pm to 6.30pm daily. Telephone appointments are available 11.30am to 12.00pm and 4.00pm to 4.30pm Mondays to Fridays (a total of 30 telephone appointments are available over the week). Extended surgery hours are offered from 6.30pm until 8.30pm on Tuesdays, and from 6.30pm until 8.45pm on Thursdays. The practice does not open on a weekend as it has opted out of providing out of hours (OOH) services to its own patients. Accordingly, between 6.30pm and 8.00am it directs patients to the OOH provider for NHS Enfield CCG.

Detailed findings

The Woodberry Practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of Maternity and midwifery services; Treatment of disease, disorder or injury; Surgical procedures; Diagnostic and screening procedures; and Family planning.

The Woodberry Practice has not previously been inspected by CQC.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 May 2016. During our visit we:

- Spoke with a range of staff (GP, nurse, practice manager, administrators and receptionists) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patients' test result following referral to specialist care showed that they needed a particular medicine which the practice prescribed without explaining, leaving the patient unsure about the need for the medicine. The problem arose due to a misunderstanding about who should have advised the patient of the test result and the need for medicine. The practice apologised to the patient and reviewed the event. It decided that information leaflets should always be sent to patients in such circumstances. It also requested that the specialist team provide the practice with detailed instructions for any required treatment.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and practice nurses were trained to child protection or child safeguarding level 3. The healthcare assistant was trained to level two, and non-clinical staff were trained to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A partner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and clinical staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. Non-clinical staff had received in-house infection control training relevant to their role. Staff we spoke to were able to explain the procedure for dealing with spillages and for receiving and handling samples from patients.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient

Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The healthcare assistant was trained to administer vaccines and medicines against a patient specific prescription or direction (PSDs) from a prescriber. PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.

- We reviewed five personnel files and found 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.

Monitoring risks to patients

Risks to patients were assessed and managed.

- The practice had an up to date fire risk assessment, but it did not carry out regular fire drills.
- 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 which identified local health and safety representatives. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- 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 enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

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

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

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

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97% of the total number of points available, with an exception reporting rate of less than 7%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-15 showed:

- Performance for diabetes related indicators was similar to the national average. For example, 77% of patients with diabetes, on the register, had a last IFCCHbA1c reading of 64 mmol/mol or less in the preceding 12 months, compared to a national average of 78%.
- Performance for mental health related indicators was similar to the national average. For example, 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had had their alcohol consumption recorded in the preceding 12 months, compared to a national average of 90%.

There was evidence of quality improvement including clinical audit.

- There had been five clinical audits completed in the last two years, two of these were completed audits where the improvements made were implemented and monitored.

Findings were used to make improvements. For example, the practice audited antibiotic prescribing relative to the assessment of patient's symptoms and vital signs. This was considered important as an aid to diagnosis. During the first cycle the practice reviewed 70 patients, and found that, for example, temperature had been recorded in the notes of 52%, while heart rate and respiratory rate were recorded for 34% and 22% of patients respectively. Antibiotics were prescribed to 47% of patients within this group. The practice discussed the importance of recording this information and agreed to be more vigilant in recording this information. On re-audit the practice reviewed 50 patients. On this occasion 74% of patients had their temperature recorded in their notes, while heart rate and respiratory rate had been recorded for 62% and 48% of patients respectively. Antibiotics were prescribed to 40% of patients, a reduction in the number receiving antibiotics compared to the first cycle. The practice concluded that recording the patient's symptoms and vital signs was beneficial in deciding whether antibiotics should be given and made it easier to explain to patients whether antibiotics were needed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, fire safety, health and safety and confidentiality. However, non-clinical staff were not completing infection prevention and control training relevant to their role.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of

Good

Are services effective?

(for example, treatment is effective)

competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. However, not all staff had received an appraisal within the last 12 months, though there was evidence of appraisals in earlier years. The practice told us that some appraisals had been delayed to enable work on QOF to be completed and that they would ensure all staff received an appraisal.
- Staff received training that included: safeguarding, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and dementia. Patients were signposted to the relevant service.
- Smoking cessation advice and a dietician were available from a local support group.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 81% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were lower than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 5 % to 48% (CCG average 10% to 60%) and five year olds from 41% to 80% (CCG average 66% to 86%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Good

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; 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 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also 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 felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and comparable to CCG and national averages for consultations with nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 89% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 80% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Good

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 80 patients as carers (less than 1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP sent them a letter expressing condolences and offering support. This was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice supported a charity for deaf people, by providing a room for counselling with a sign language interpreter.
- The practice ran memory screening clinics to identify and support patients with memory problems.
- For patients with limited mobility the computer system alerted staff to the need to book an appointment in a ground floor room.
- The practice offered extended hours clinics on a Tuesday evening until 8.30pm, and until 8.45 on Thursdays for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. Appointments were from 9.00am to 12.30pm and 2.00pm to 5.30pm daily, with on-call doctors available from 8.30am to 11.30am and 4.00pm to 6.30pm daily. Telephone appointments were available from 11.30am to 12.00pm and 4.00pm to 4.30pm Mondays to Fridays (a total of 30 telephone appointments were available over the week). Extended surgery hours were offered from 6.30pm until 8.30pm on Tuesdays, and from 6.30pm until 8.45pm on Thursdays. The practice did not open on a weekend as it had opted out of providing out of hours (OOH) services to its own patients. Accordingly, between 6.30pm and 8.00am it directed patients to the OOH provider for NHS Enfield CCG. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

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

- 66% of patients were satisfied with the practice's opening hours compared to the local average of 77% and the national average of 78%.
- 68% of patients said they could get through easily to the practice by phone compared to the local average of 68% and the national average of 73%.

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

The practice had a system in place to assess:

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

This was done by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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 information was available to help patients understand the complaints system including leaflets and information about how to make a complaint was on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at 11 complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way, with openness and transparency when dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to improve the quality of care. For example, a patient complained that their online repeat prescription request had not been processed. The practice investigated and found that the prescription had been issued but that the pharmacy had not dealt with it. The practice apologised to the patient and explained what had happened. The practice reflected on the complaint and provided further training for all reception staff in the electronic prescribing system.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The practice had a mission statement, and a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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

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

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG asked the practice to improve the appointments system. The practice re-assessed its appointments and increased on the day appointments to 50% of all appointments (from 36% previously). It also increased the number of appointments that were bookable online to 25 appointments a week.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Reception staff had implemented a handover diary so that any outstanding action was completed. Staff told us they felt involved and engaged to improve how the practice was run.

Are services well-led?

Good

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

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had at the request of NHS Enfield CCG become a hub for the community anticoagulation service. Before the service commenced three clinicians underwent further training.