Church Lane Surgery

Quality Report

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Date of inspection visit: 23 October 2014
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Church Lane Surgery on 23 October 2014. We rated the practice as 'Good' for the service being safe, effective, caring, responsive to people's needs and well-led. We rated the practice as 'Good' for the care provided to older people and people with long term conditions and 'Good' for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- The practice was visibly clean and infection control procedures were in place. Staff understood their responsibility to raise concerns and report incidents. Staff learnt from the outcomes of investigations into incidents and complaints. The practice had policies and procedures to monitor safety and respond to risk.
- Patients were offered effective care from GPs who met their medical needs. Staff were qualified and trained and had the skills to carry out their role effectively.
- Patients felt supported and said they were treated with dignity and respect by their GP.
- Patients needs were met through the way in which services were organised and delivered. The appointments system was easy to use and overall patients were satisfied with the availability of appointments.
- The leadership, management and governance of organisation and the practice supported learning and innovation. Staff and patients were involved in developing services and planning for the future.

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

- The provider should ensure all clinical staff are aware of the Mental Capacity Act 2005 and how this will impact on care and treatment.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from NICE and used it routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs have been identified and planned. Staff received personal development and had annual appraisals. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice as good or very good in most aspects of their care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was in an accessible format. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients reported good access to appointments and said they had continuity of care. Many of the patients we spoke with said they had a preferred GP who had been involved with their care and that of their family for a number of years.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a very active patient participation group (PPG).

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 and enhanced services for unplanned admissions. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice offered a full range of immunisations for children. The practice phoned parents and invited them to bring in their babies/ children at the relevant time for childhood immunisations. The overall uptake of the various childhood vaccinations was in line with the CCG average. However there was some variation in childhood immunisation rates. For example, 55.1% of babies at the practice had received the vaccination for meningitis. The CCG average for the uptake of this vaccination was 47.2%. The uptake for the Infant Hib vaccination (protection for children under five against severe bacterial infections) stood at 58.1%, as compared to the CCG average of 76.7%.

Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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

Summary of findings

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 reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was able to offer patients registration on a temporary basis, for example homeless people. Patients who required urgent medical treatment were able to register at the practice for this. The majority of patients were from the Sri Lankan Tamil community. The practice was able to offer support, healthcare and health promotion effectively due to their ability to communicate in their language.

People experiencing poor mental health (including people with dementia)

Good

The practice had systems in place to signpost patients with poor mental health about how to access a support organisation such as EACH a voluntary organisations in Brent offering support to people from diverse communities. Patients who need an assessment of their mental health were referred to the Improving Access to Psychological Therapies Team.

Summary of findings

What people who use the service say

Patients said they were happy with the service they received. Many patients had been visiting the practice for a number of years and said they had confidence in the skills and the knowledge of their GP. Patients said it could be difficult sometimes to get an appointment but staff at reception did their best to find an appointment slot which suited them.

The majority of the patients we spoke with were members of the PPG. They said the practice listened to them and tried to accommodate their suggestions for improving the service. Patients commended the text appointment reminder service and thought this might have helped the practice to decrease the number of missed appointments.

Areas for improvement

Action the service SHOULD take to improve

The provider should ensure all clinical staff are aware of the Mental Capacity Act 2005 and how this will impact on care and treatment.

Church Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The GP was granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Church Lane Surgery

Church Lane Surgery provides NHS primary medical services. The practice is part of the Harness Care Co-operative Limited which has a membership of 21 practices. The practice provides primary medical services through a GMS contract to approximately 8,076 patients in the local community.

The practice is part of NHS Brent Clinical Commissioning Group (CCG) which is made up of 67 GP practices. The practice's patient age distribution was predominantly in the 0 - 14 years age group and 25-39 age groups. Patients in the age range of 55 – 85 were significantly lower than the England average.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice staff team comprised of four GPs one of whom was female, a practice nurse, one health care assistant and a practice manager, who were supported by reception and administration staff. The practice offers a range of services including childhood immunisations, health checks, travel vaccinations, and a phlebotomy service. The practice opening hours are Monday to Friday 8.30am to 5.30 except Thursday when the practice does not offer appointments after 11am. Patients had the option of attending an appointment at local Harness GP Cooperative Hub in Wembley when the practice was closed. The Harness GP Cooperative Hub was open until 8pm on week days.

Extended hours are on Monday evening until 8pm. The practice has opted out of providing out-of-hours services to its patients and refers patients to the 111 out-of-hours service.

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. This 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

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 23 October 2014. During our visit we spoke with a range of staff including two GPs and a receptionist/ administrator. We spoke with six patients who used the service. We viewed Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, significant events and comments and complaints from patients. Staff we spoke with were aware of their responsibilities to raise concerns and report incidents. For example, following a patient falling in the consultation room, staff were instructed to remind patients of any risks associated with climbing onto the consultation couch.

We reviewed incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We looked at four records of significant events which had been recorded between July 2014 and September 2014. There was a slot for discussing learning from significant events in the monthly practice staff meeting. All staff including reception staff and nursing staff attended dedicated significant events meetings and this was evidenced in the records we viewed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all of the GPs, the practice nurse and the health care assistant had received training in child protection. The GPs had received training in child protection to Level 3. All other staff had received child protection training to Level 2. All staff had attended training in safeguarding adults, organized by Brent Social Services.

Separate policies and procedures were available for recognising the signs of abuse in both adults and children. Staff at the practice were aware of the London Borough of Brent multi-agency procedures for reporting safeguarding concerns.

The practice had a dedicated GP appointed as the lead in child protection and safeguarding adults who could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke to were aware of the lead and reception staff said they would report concerns they had to the lead or one of the other GPs. At the time of the inspection there were no patients who had been identified in this category.

There was a system to highlight vulnerable patients on the practice's electronic records. Patient records would have an alert attached, and this would show on the screen as soon as their records were accessed by practice staff.

Reception staff undertook the role of chaperone when this was required. A chaperone policy was in place and staff had received training in the chaperone guidelines and how to offer good patient care when they were chaperoning. Staff informed us once chaperoning duties had been carried out a record of this was made on the patients electronic record by the GP and the chaperone. Staff we spoke with understood their responsibility when acting as chaperone. All staff had received Disclosure and Barring checks.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerator and found they were stored securely and only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. This was being followed by the practice staff. A record was available of daily checks of the refrigerator temperature. Processes were in place to check medicines were within their expiry date and suitable for use. A record was available of daily checks of the refrigerator temperature and weekly checks and of medicine expiry dates.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness and infection control.

The practice had a contract with a cleaning agency. We looked at the service agreement between the practice and the agency which set out the cleaning tasks to be

completed daily, weekly and monthly. The practice manager monitored the work carried out by the agency and a record was made of any areas where cleaning had not been carried out to a satisfactory standard.

The practice had a lead for infection control and infection control policies and procedures were available for staff to refer to. The aim of the procedure was to set out the action required to minimise the risk of transferring infection to patients and staff. The procedure provided links to relevant infection control publications and external local agencies such as the Community Infection Control Team. All staff had received training in infection control.

We saw evidence that the last infection control audit had been carried out in August 2014. The audit covered documentation, cleaning of the practice including consultation rooms, hand hygiene, waste management and the storage of samples. Where an area of improvement had been identified this had been noted and actioned. For example, discussing the protocol for a needle stick injury at the practice meeting. The practice had carried out a risk assessment on the risk of Legionella. The risk was assessed as minimal due to cold water being provided directly by the mains and there being no cold water storage tank.

Equipment

Staff we spoke with informed us that equipment was maintained and tested regularly. The practice employed an external contractor to service equipment. We saw records which evidenced that maintenance and calibration of all equipment, for example weighing scales. had been carried out in May 2014. We received information to confirm that Portable Appliance Testing (PAT) had been carried out for domestic appliances in January 2015. Computers and printers had been replaced within the previous two years.

Staffing and recruitment

We looked at the recruitment records of two clinic members of staff. Records showed that appropriate recruitment checks had been undertaken prior to employment including proof of identification, references, qualifications, criminal records checks via the Disclosure and Barring service (DBS) and registration with the appropriate professional body. The practice had a recruitment policy to set out the standards it followed when recruiting clinical and non clinical staff. The HR department of Harness Care Co-operative Ltd were responsible for obtaining DBS checks for all members of staff. We saw correspondence from Harness to confirm that DBS checks for all members of staff had been countersigned in preparation for renewal.

Monitoring safety and responding to risk

The practice had systems in place to monitor risks to patients staff and visitors to the practice. These included annual and monthly checks to the building, medicines management and dealing with emergencies.

Identified risks were recorded on a risk assessment tool which had been completed January 2014. Risks which had been reviewed included electrical and fire safety, and risks to patients and staff whilst on the premises, for example, potential accidents. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk.

We saw that staff were able to identify and respond to changes to patients including health and wellbeing of patients. For example patients experiencing poor mental health were given the contact details of the emergency psychiatric service. Arrangements were in place to offer children under the age of ten same day emergency appointments.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records which indicated all members of staff had received training in basic life support in January 2014. Emergency equipment was available including access to oxygen and a defibrillator.. A notice was displayed in consultation rooms advising staff of the location of emergency medicines and equipment. There was a kit containing emergency medicines and we saw that this was regularly checked and up to date.

The practice had a health and safety policy and procedure with members of the practice team designated to lead on areas such as fire safety (fire marshal) and infection control. A risk assessment for all of the activities which take place at the practice had been completed in January 2014. The risk assessment identified potential hazards in the areas of patient and staff safety, infection control, safety of the premises and fire safety. Where risks had been identified

Good

Are services safe?

control measures were in place to minimise them. A new fire alarm system had been installed which meant the first annual safety service had not taken place at the time of the inspection.

The practice had a business continuity plan in place to deal with a range of emergencies that may impact on the daily operation of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE). GPs reported they referred to NICE guidelines in every day practice.

Risk assessments were completed for patients who were assessed as being at risk of an emergency admission to hospital. Patients treatment and their wishes in relation to their care was recorded and was available to other health care professionals. A system called 'Coordinate My Care 'was used for patients who may be treated by a number of different health care professionals

One GP at the practice was the senior partner who took the lead in clinical work. Another GP was the lead for child protection and safeguarding adults. Scheduled clinics for medical conditions such as diabetes were not held at the practice. However, the practice nurse took the lead in assessing and supporting patients with long term medical conditions. The practice nurse offered travel vaccinations, childhood immunisations and sexual health support and advice

Older patients who were identified as at risk of an unplanned admission to hospital were identified and arrangements were made to offer these patients an appointment to attend the practice for care planning with the practice nurse and a GP. Quarterly reports were produced to identify patients who had reached the age of seventy five.

Management, monitoring and improving outcomes for people

The practice showed us two clinical audits which had been undertaken. A prescribing audit had been carried out to ensure GPs were prescribing in line with national guidance. The prescribing audit was due to be submitted to the CCG at the end of 2014. The aim of the audit was to identify where improvements to prescribing practice could be made. The three areas identified by the audit were to ensure all prescriptions had a duration of up to two months, that all prescribed medications had appropriate dosage instructions and to ensure patients on repeat prescriptions were offered a medication review every six months. The date for the re audit of this information had been identified as January 2015.

An audit had been carried out on blood test samples which were sent to the laboratory. The results showed a significantly high level of potassium (a condition known as hyperkalaemia) in many samples. The practice reviewed this information and found that there was a delay in the courier delivering the samples to the laboratory which meant sample readings were not always correct. The practice investigated this and changed the arrangements with the contracted courier to ensure blood samples were delivered promptly. A re audit of this information was carried out approximately two months after the initial audit thus completing the audit cycle. The result of this was a reduction in the number of patients presenting with spurious hyperkalaemia.

The practice used the Quality and Outcomes Framework (QOF) to monitor benchmark and improve the service. QOF is an annual reward and incentive programme detailing GP practice achievements. For example, the management of chronic disease, patients experience of their care, additional services and how well the practice is organised. QOF were audited monthly and as a result patients who were on the chronic disease register were contacted by phone or text, and a request was made for them to make an appointment for a review of their condition. The practice had achieved 97% in their Quality and Outcomes Framework (QOF) performance over the previous year.

Effective staffing

Practice staff included the principal GP who worked full time, four part time GPs, a part time practice nurse and a health care assistant. A practice manager, administrator and four receptionists also worked at the practice.

GPs were up to date with their yearly continuing professional development requirements and had either been revalidated or given a date for revalidations. GPs that had not been revalidated were assigned a responsible officer who was accountable for their appraisal and revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England.

Good

Are services effective?

(for example, treatment is effective)

The practice nurse had defined duties they were expected to perform. We saw evidence that the practice nurse had been appraised by the principal GP and had a learning and development plan. The practice nurse informed us she was required to undertake five training days per year and this was a requirement of the Nursing and Midwifery Council. The practice nurse had undertaken training in child immunisations, chronic disease management, new patient screening and chaperoning.

Staff had annual appraisals which identified learning needs and an action plan was developed as a result. Staff we spoke with said they felt well supported at the practice. Staff meetings were held once a month and minutes reviewed demonstrated that learning from significant events took place

GPs attended monthly clinical meetings with other practices from the Harness GP Co-operative which is a consortium of GPS in the Brent CCG area. Minutes of these meetings evidenced that training and development was a feature of these meetings. GPs were able to present a case history (usually to review complex medical treatment needs) for discussion at the group. Guest speakers such as treatment specialists or consultants from a local hospital were invited to meetings to give a presentation. Commissioning services and improving facilities for patients were also discussed at network meetings.

The Harness Network also holds a meeting four times a year for practice managers and practice nurses. The aim of these meetings was to discuss primary medical practice themes and address any problems as a group. The last Harness Practice Managers and Nurse Meeting took place in September 2014. A representative from Church Lane practice attended. Nurses and practice managers discussed areas of patient care for example community based health services, health promotion for patients and the use of cardiology equipment.

Working with colleagues and other services

Staff at the practice were able to outline their responsibility for managing patient information. Blood tests, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received electronically and by post.

The practice held multidisciplinary team meetings to discuss the needs of complex patients, such as those with end of life care needs or patients who may be vulnerable.

We saw evidence of weekly meetings held between the practice, district nurses and the palliative care team to discuss the treatment of patients receiving palliative care. Multi-disciplinary team meetings were also held monthly for GPs and health care professionals within the Brent Harness group.

At the time of the inspection Harness GP Consortium were in the process of recruiting a health and social care coordinator as a vacancy had just arisen. The role of the coordinator was to ensure patients who were receiving health care and social care, for example domiciliary, had their care coordinated between the two types of service.

The Harness Network also held a meeting four times a year for practice managers and practice nurses. The aim of these meetings was to discuss primary medical practice themes and address any problems as a group. The last Harness Practice Managers and Nurse Meeting took place in September 2014. A representative from Church Lane practice attended. Nurses and practice managers discussed areas of patient care for example community based health services, health promotion for patients and the use of cardiology equipment.

Information sharing

Patients individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which collated all communications about the patient including scanned copies of correspondence from hospitals and other health and social care services. We spoke with reception/administrative staff regarding the management of results were received electronically or scanned onto the patient record if they came in paper form. The GP was the recipient of test results. GPs were able to send a 'task' using this system, to administrative staff requesting contact was made with patients where a follow up appointment was necessary.

The practice used electronic systems to communicate with other providers. The practice had systems in place to provide staff with the information they needed. An electronic patient record EMIS was used by all staff to coordinate, document and manage patients care. This software enabled scanned communications, such as those from hospital to be saved in the system for future reference.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

We found that not all staff were fully aware of Mental Capacity (MCA) Act 2005 and Gillick competencies. We spoke with clinical staff about the use of the MCA when assessing and treating patients and some were not aware of how the act would be used in practice with patients who may lack capacity. Staff we spoke with had an awareness of Gillick competency and how this would be used with young patients. (Gillick competencies help clinicians identify children under the age of sixteen who have the legal capacity to consent to medical examination and treatment.)

Health promotion and prevention

All new patients registering with the practice were offered a health check with the practice nurse. The practice offered health checks to all its patients aged 40 – 74. The practice kept a register of patients with learning disabilities.

Spirometry testing had just been initiated. (Spirometry is a test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease (COPD)). Clinical staff informed us that the number of patients who were recorded as having COPD was low. The reason for this was that the practice had a young population on their register. Smoking cessation advice was available at the practice for patients who needed this service.

The practices performance for cervical smear uptake was 83%, the target set for the practice was by the CCG was 80%. A reminder was placed on the patient electronic record to alert practice staff when they were due. Patients who visited the practice for contraception advice were also given a date for their next appointment. Three GPs and 60% of patients spoke the Tamil language. For the purpose of performing smear tests the practice nurse had translation cards to show patients and give them the information they required for this procedure.

Staff at the practice phoned parents to arrange childhood immunisations. At the time of the inspection there were up to 350 children at the practice under the age of five. The overall uptake of the various childhood vaccinations was in line with the CCG average. However there was some variation in childhood immunisation rates. For example, 55.1% of babies at the practice had received the vaccination for meningitis. The CCG average for the uptake of this vaccination was 47.2%. The uptake for the Infant Hib vaccination (protection for children under five against severe bacterial infections) stood at 58.1%, as compared to the CCG average of 76.7%. We were informed by staff that parents were phoned and invited to bring in their babies/ children at the relevant time for childhood immunisations.

Emergency contraception was available for patients who requested this. Patients who were identified as being at risk of flu were offered flu and pneumococcal (pneumonia vaccine).

The percentage of patients with a physical or mental health condition whose records contained an offer of support within the preceding 15 months was higher than the national average. The practice used an external counselling organisation for patients who speak Tamil who were experiencing mental health problems.

Notices in the patient waiting room and the patient website signposted patients to information on a number of health care conditions.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. Our finding were based on what we found in the 2014 national GP patient survey, a survey of 282 patients undertaken by the practice in September 2013, 26 CQC comment cards completed by patients and the views of four patients we spoke with on the day of the inspection. Evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, information from the patient survey showed that patients rated their care as 'good' or 'very good'. Patients said that the practice staff treated them with concern.

All of the patients who completed CQC comment cards said they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Although information on all of the comments cards was favourable, two comments were less positive but there were no common themes to these.

The majority of the patients we spoke with had been registered with the practice for a number of years. They said their GP was aware of their medical history and personal circumstances and they valued this.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The majority of the patients we spoke with had been registered with the practice for a number of years. They said their GP was aware of their medical history and personal circumstances and they valued this.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2013/2014 national patient survey showed 81% of practice respondents said the GP was good or very good at involving them in decisions about their care and 89% felt the GP was good or very good at explaining treatment and results.

The proportion of patients who responded said the GP was good or very good at involving them in decisions about their care.

Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed

Respect, dignity, compassion and empathy

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Are services caring?

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Patients we spoke to on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us Tamil and English was spoken by clinical and non-clinical staff. The majority of patients registered at the practice spoke Sri Lankan Tamil. Some notices for patients on key information were written in Tamil.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example the proportion of patients who responded to the patient survey said that both GPs and the nurse was good or very good at treating them with care or concern.

People we spoke with said staff listened to them and gave them time and consideration. One patient explained how staff had given excellent support to their family during a very difficult time. The practice referred patients to Improving Access to Psychological Services (IAPT) and a voluntary organisation called EACH for psychological support and bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). The practice had a well-established PPG with up to twelve members. We met with five members of the PPG as part of this inspection. Members felt listened to by the practice were engaged in the process of working with them. Some of the changes made at the practice as a result of the PPG were:-

- There were now four half hour slots allocated daily for GP telephone consultations sessions.
- Patients were sent text messages to remind them of pre booked appointments. This had led to a decrease in the number of DNA's (appointments were patients have not attended.)
- Patients were able to consent for their repeat prescription(s) to be forwarded directly to a pharmacy of their choice for collection.

A notice advertising the PPG was displayed in the patient waiting area.

The Harness GP Cooperative held a PPG meeting once every two months, patients and staff representatives from the 21 practices were invited to attend the meeting. We saw evidence of joint working between staff and patients in the minutes of PPG meetings.

Patients and staff were invited to a Harness System Redesign Event which took place in October 2014. The event was in response to the Prime Minister's Challenge Fund (PMCF) and Transforming Primary Care. The event was divided into two sessions of table top discussions. The first being a discussion on the redesign of the current provision to reflect Harness practices and the Network. The second table top discussion covered the topics of urgent care, continuation of care, convenient care and care for older people with complex needs.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice and a GPs/and reception staff who spoke two languages English and Tamil. The practice informed us that the majority of patients were Sri Lankan Tamils with considerable educational and socio-economic disadvantage. Staff at the practice commented that their understanding of this community assisted them to understand and support patients needs.

Access to the service

Morning appointments were available from 8.30 am to 11am Mondays to Fridays. Afternoon appointments were available 3.00pm to 5.30 pm except Thursday. The practice's extended opening hours on Monday between 6.30 and 8.00pm this was particularly useful to patients with work commitments.

Patients confirmed that improvements had been made to the appointments system as a result of feedback from the PPG. Patients we talked to said that they were able to make an appointment with the GP of their choice. Some patients and their families had a long history of positive care from one particular GP and were willing to wait 2/3 days for a non urgent appointment. Many patients were impressed with the text reminder system which had been introduced at the practice; the text also included the name of the GP or practice nurse they were booked with for their consultation. One patient mentioned the value of evening appointments for working people, and thought that reception staff were aware of working patients and offered them the evening appointments. Patients were aware of the telephone consultation option if they had the need for an urgent/same day appointment. A telephone queuing message service for patients was in place informing them of their place in the queue.

There was evidence of multi-disciplinary team meetings to review the care of people on the palliative care register. Arrangements could be made for patients who were housebound to receive a home visit from their GP.

Home visits were available for older people and people with long term conditions who were unable to travel to the practice. Appointments were available outside of school hours daily, with appointments available until 8pm on Mondays for working people.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information from the 2014 national GP Patient Survey informed us that patients were fairly satisfied to very satisfied with their GP practice opening hours. Data from the 2013/14 national patient survey showed 79% of respondents said they were able to get an appointment to see or speak to someone the last time they tried. 84 % of respondents said the last appointment they got was convenient. Survey results also indicated that the practice was in line with the national average for access to the practice by phone and making an appointment.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments. Patients also had the option of attending a local walk in Centre or Urgent Care Centre if they wished to be seen immediately. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients on the practice answer phone. Patients had the additional option of attending an appointment at local Harness GP Cooperative Hub in Wembley. This was open until 8pm on week days.

The practice was situated on the first and second floors of the building with the majority of services for patients on the first floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Support was available for working patients. An online booking system was available on request by patients. The main method of booking an appointment was in person or by contacting the practice by telephone. Patients were able to phone the practice and book a telephone consultation. Reception staff were available between 8.30 and 6pm daily apart from Thursday when the practice closed at 6pm.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. 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, a poster was displayed, and information was available on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

Staff explained that it was possible to defer complaints by talking with patients and taking the time to explain why something had not taken place, for example, a patient not being able to book an appointment with a GP of their choice.

We looked at the three complaints received in the last twelve months and found these were satisfactorily handled and dealt with in a timely way. Some complaints had also been recorded and investigated as a significant event/ incident.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's five year business plan. The practice vision was to integrate the health and social care services with a view to facilitating the patient journey. As a member of the Harness GP Consortium staff and patients had participated in events to look at the future the future of general practice.

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. We looked at the report from the August 2014 peer review which showed that the practice had the opportunity to measure their service against others and identify areas for improvement. Two examples of this peer review were to look at the number pf patient health checks and Chlamydia screening achievement. Health check invitations had been sent out to 89 patients at the practice, 71 health checks had been completed. The Chlamydia screening results indicated that the practice had carried out a high level of screening and had identified negative and positive results.

The practice had completed a number of clinical audits, for example, an audit had been carried out on the number of patients with hyperkalaemia. As a result of this, changes were made to the courier arrangements for transporting blood samples to the laboratory. The practice had carried out a repeat prescribing audit. We were able to see the repeat prescribing audit sent to the CCG dated December 2014. As a result of this audit the practice had identified changes to be made regarding repeat prescribing. The next audit cycle was due to be repeated and submitted to the CCG in in February 2015.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the PPG. We looked at the results of the annual patient survey sent to patients through the PPG. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The PPG contained representatives from various population groups such as patients who work, retired patients, patients representing ethnicity and age, men and women.

As a result of the patient survey some changes were made at the practice. A locum GP and part time nurse were employed to meet the demand for appointments within a 48 hour time frame. Improvements were made to the facilities, seating and flooring was replaced in reception and the patient toilets were decorated.

Harness GP Consortium had carried out an Access Project between June 2012 and Mar 2013. The access project found that 80% of patients booked their appointment by phone and 71% said it was easy to get through to the practice by phone. With regards to hours and availability 61% said they were able to see a GP within two days and 97% of patients questioned are satisfied / fairly satisfied with their surgery opening hours.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at the practice nurse staff file and saw that regular appraisals took place which included a personal development plan.

Staff said the practice was very supportive of their training and that they attended Harness GP Consortium network meetings were guest speaker and trainers attended.

The practice had a robust approach to incident reporting in that it reviewed all incidents at the practice. An example of this was patients being made aware of a risk when they were moving onto the examination couch.