PHGH Doctors

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?	Requires improvement
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 an announced comprehensive inspection at PHGH Doctors on 16th September 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and 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.

We saw one area of outstanding practice:

- Palliative patients (those nearing the end of their lives), and their carers, were given access to their GP's private mobile number to use at any point during a 24 hour period should they need to raise concerns or discuss aspects of care and treatment. This was particularly helpful for the practice's Jewish population as religious custom dictates that when a patient passes away burial should take place with no undue delays.

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

Importantly the provider must:

Summary of findings

- Ensure that staff acting as chaperones are appropriately trained and have the required Disclosure and Barring service (DBS) checks.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure that all patient group directions (PGD's) are current for all nursing staff prescribing immunisations and vaccinations.

Importantly the provider should:

- Ensure the appointment system reflects the needs of patients. For example, enabling patients to access an appointment with a preferred GP to provide continuity of care wherever possible.
- Improve the availability of nurse led appointments.
- Ensure there are appropriate levels of nursing provision to meet the needs of patient
- Increase the number of identified carers to 10% of the patient population in order to better support patients in managing their care and treatment.

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.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. 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. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, in regard to medicine management; we found no patient group directions in place for the practice nurse who had been giving vaccinations to adults and children without approval. We found that members of non-clinical staff identified and used to perform chaperone duties had not always been Disclosure and Barring Service checked or appropriately trained as chaperones.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were mostly at or above average for the locality. Where there were identified areas for improvement staff had plans in place to improve performance; for example, checks for patients with diabetes. . Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' 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 had been identified and appropriate training planned to meet these needs. There was evidence of appraisals for staff. 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 higher than others locally 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. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example services for vulnerable older people. 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. Learning from complaints was shared with staff and other stakeholders. However, patients said they did not find it easy to make an appointment with a preferred GP due to the availability of appointments but felt there was continuity of care. Urgent appointments were available the same day.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. 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 were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those patients who are most vulnerable.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 held registers of patients whose circumstances made them vulnerable, for example drug and alcohol dependent patients, and those patients with a learning disability. It had carried out annual health checks for people with a learning disability and follow ups were arranged for all these patients. It offered longer appointments for patients who needed them.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access support groups and voluntary organisations and worked with specialised agencies, for example to assist patients who were refugees. 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.

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). There was a GP lead for mental health who ensured that all patients had their annual health check. If patients did not attend they were visited at home to ensure appropriate monitoring and care. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. For example, there was a weekly talking therapy clinic available for patients experiencing mild to moderate mental health issues. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. Staff had received dementia awareness training.

Summary of findings

What people who use the service say

The national GP patient survey results published July 2014 showed the practice was performing in line with local and national averages with the exception of access to a GP of choice (where performance was below local and national averages). There were 117 responses and a response rate of 1.15% of the patient population.

- 76% find it easy to get through to this surgery by phone compared with a CCG average of 63.4% and a national average of 74.4%.
- 79.6% find the receptionists at this surgery helpful compared with a CCG average of 82.6% and a national average of 86.9%.
- 44.5% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 55.8% and a national average of 60.5%.
- 86.5% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 82.2% and a national average of 85.4%.
- 96.6% say the last appointment they got was convenient compared with a CCG average of 89.8% and a national average of 91.8%.
- 70.7% describe their experience of making an appointment as good compared with a CCG average of 67.7% and a national average of 73.8%.
- 70.5% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 57.4% and a national average of 65.2%.
- 72.2% feel they don't normally have to wait too long to be seen compared with a CCG average of 50.2% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 45 comment cards which were all positive about the standard of care received. Reception staff, nurses and GPs all received praise for their professional care and patients said they felt listened to and involved in decisions about their treatment.

Patients informed us that they were treated with kindness and compassion by staff at the practice. They also felt well supported and looked after. We also spoke with two members of the PPG and six patients attending the practice for appointments on the day of our visit. They told us they could not fault the care they had received.

However, patients told us it had often been difficult to access routine appointments with their preferred GP to discuss on going medical conditions, they told us sometimes more than three weeks. Patients did tell us they were able to access other GP's if an urgent need arose.

PHGH Doctors

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a second CQC inspector, GP specialist adviser, and a practice nurse specialist adviser.

Background to PHGH Doctors

PHGH Doctors is situated in Hampstead Garden Suburb in NHS Barnet Clinical Commissioning Group (CCG), north London. The practice holds a Primary Medical Services contract (an agreement between NHS England and general practices for delivering personal medical services). The practice provides a full range of enhanced services including adult and child immunisations, facilitating Timely Diagnosis and Support for People with Dementia, and minor surgery.

The practice is registered with the Care Quality Commission to carry on the regulated activities of Surgical procedures, Maternity and midwifery services, Treatment of disease, disorder or injury, Family planning, Diagnostic and screening procedures.

The practice had a patient list of just over 10,100 at the time of our inspection.

The staff team at PHGH Doctors included two GP partners, five salaried GPs', one Nurse practitioner, one practice Nurse, and one phlebotomist. The practice has two senior practice administrators (who manage the practice on a day to day basis), and ten administrative staff. The GPs compromised of two male and five female GPs. The practice nursing team were female. All staff work a mix of full time and part time hours.

The practice is open between 8.30am and 6.30pm Monday to Friday. Extended hours surgeries are offered on Thursday morning from 7.30am to 8.30am, Friday morning 7.15am to 8.00am, Friday evening 6.30pm to 7.00pm and Saturday mornings 9.15am to 12.15pm. To assist patients in accessing the service there is an online booking system, and a text message reminder service for appointments and test results. Urgent appointments are available each day and GPs also complete telephone consultations for patients. An out of hour's service provided by a local deputising service covers the practice when it is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on their circumstances. Information on the out-of-hours service is provided to patients on the practice website as well as through posters and leaflets available at the practice. There are four or five GPs consulting each morning and three GPs consulting in the afternoons. On a Saturday morning one GP provides consultations. There are forty GP sessions available per week. The practice nurses have eighteen sessions available per week and the phlebotomist has four.

The practice had a lower percentage than the national average of people with a long standing health conditions (40.7% compared to 54.0%); and a lower percentage than the national average of people with health related problems in daily life (44.5% compared to 48.8%). The average male and female life expectancy for the Clinical Commissioning Group area was higher than the national average for males and in line with the national average for females.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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.

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 September 2015. During our visit we spoke with a range of staff including GPs, the nurse practitioner, and administrative staff. We spoke with patients who used the service including two representatives of the patient participation group (PPG). We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 45 comment cards where patients and members of the public shared their views and experiences of the service. We also reviewed the practice's recent patient satisfaction survey results from 2014/15 provided prior to our visit.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice administrators of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto a system and automatically treated as a significant event where appropriate. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, an incident regarding an urgent blood result potentially could have put a patient at risk because the message from the laboratory was not escalated using the appropriate procedure. The issue was reported and discussed in the practice at a meeting. Discussions resulted in a review of procedure, staff updates and additional safeguards to ensure this event did not reoccur.

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

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a 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 relevant to their role.
- A notice was displayed in the waiting room, advising patients that staff were available to act as chaperones, if required. The practice had seven staff members who acted as chaperones. Six of which had been trained for the role and had received a disclosure and barring service check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We found that one member of staff who told us they were regularly acting as a chaperone had not received the appropriate training and no completed DBS check has been recorded. We found that no risk assessment had been undertaken in regard to chaperoning at the practice. We brought this to the attention of the Practice Administrator who informed us that a DBS check had been recently applied for and that the staff member concerned would no longer be acting as a chaperone until a satisfactory DBS check had been returned, appropriate chaperoning training completed and a risk assessment undertaken. Staff took appropriate action to keep patients safe from the risk of harm.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment had been checked in the last year to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, fire safety and infection control.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. A GP partner had been identified as 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 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. For example, new chairs for the waiting area had been ordered to ensure they met with hygiene standards. We noted that the review of legionella risk assessment had been organised for October 2015.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. However, although we saw patient group directions (PGD's) in place for the Nurse practitioner there were none for the Practice Nurse. 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. For example, the nurse prescribing vaccinations to children should be covered by a PGD. We raised this with practice staff who were unaware that these had not been put in place since the appointment of the Practice Nurse. GP leads informed us that until these were satisfactorily in place the Practice Nurse would no longer be administering vaccinations without having the appropriate GP prescriptions or PGDs.
- Recruitment checks were carried out at the practice and included proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. We reviewed seven staff files; five permanent staff and two locum staff. We found that in all but one file appropriate recruitment checks had been undertaken prior to employment. For example, we found no DBS check had been undertaken or applied for, no proof of identification and incomplete reference checks. We raised this with the Practice Administrator and GP partners who informed us that this was a staff member who had started in July 2015 to the non-clinical team and that attempts had been made to obtain such information and processes were underway to resolve these recruitment issues. We found that no risk assessment had been undertaken prior to starting this staff member.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. GP's told us that they were in the process of increasing nursing capacity as they had identified a need to provide improved access for patients for health promotion and general practice nursing. Planned improvements included the training and introduction of a health care assistant and increased availability of practice nurse appointments by increasing the number of available hours worked.

Arrangements to deal with 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. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a 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 carried out assessments and treatment 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 ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet 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 participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 91.3% of the total number of points available, with 5.5% exception reporting. This practice was an outlier for some QOF clinical targets. Data from 2013/14 showed performance for diabetes related indicators was 73.9% which was lower than the CCG of 90.3% and the percentage of patients with hypertension having regular blood pressure tests was 69.47 % which was below the CCG average and the national average 83.11%. In response to those areas where performance was below average, the GP lead for diabetes told us they were due to commence further training on the management and treatment of diabetes in order to further engage patients at a practice level and reduce the number of attendances at hospital for monitoring and treatment. They told us the aim was to improve patient education and encourage a more holistic approach to the management of the condition and any related conditions.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We were shown two clinical audits conducted in the last two years, both of these were completed audits where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, a review of patients taking Anastrazole (a hormone therapy used in the treatment of breast cancer) to assess the impact on bone protection management resulted in five patients receiving a follow up to obtain a baseline on bone density in cycle one of the audit in September 2014. Of the five; four patients attended scans and results were analysed and with clinical assessments and decisions made with patients which included starting medication for Osteopenia (early signs of bone loss that can develop into osteoporosis) or Osteoporosis. This audit was repeated in May 2015 at the end of cycle two and no further cases were identified. GP's concluded that those patients being prescribed Anastrazole would benefit from bone protection management; of the seventeen patients identified on this medication, four had been diagnosed with Osteopenia or Osteoporosis.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- 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 these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and customer care management. Staff had access to and made use of e-learning training modules and in-house training.
- There was clinical supervision for nursing staff and arrangements were in place for GPs' continuing professional development, appraisal and revalidation. Clinical staff regularly took part in Community Education Provider Network (CEPN) events that

supported cross organisation multi professional NHS workforce development. GP's also attended various training events of specialist areas of interest such as mental health and addiction.

- The GP partner carrying out minor surgery met the accreditation requirements of the NHSE England service specification for the minor surgery enhanced service.

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 test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance. GP's were also aware of Gillick competence and could demonstrate how these principals were used in various examples.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to relevant services for example services for people with complex mental health problems, drug and alcohol problems and for people who are the victim of domestic abuse. The practice received regular updates from the CCG about new services and service changes. Specialist support clinics were available for patients with COPD and Asthma via a trained nurse who visited the practice on a monthly basis. There was a weekly counselling service for patients with mild to moderate mental health needs and on a monthly basis an alcohol misuse service was available for those patients who needed support. GPs also had access to a wide range of external services where patients could be referred. GPs had a comprehensive knowledge of local community services and proactively referred patients for support. Services included Barnet Carers Association, Barnet Mind, Barnet drugs and alcohol service, and other local charities such as Jewish Care, who provide social care support and housing to the local Jewish community which are large proportion of the practice patients list. For example the practice accessed a local Jewish Ambulance Service charity which provides fully trained paramedics to the local Jewish population providing onsite support when a medical emergency had arisen thus reducing the need to use the London Ambulance Service.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 78.25%, which was comparable to the CCG average of 80.4% and the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 83% to 91% and five year olds from 71% to 98%. Flu vaccination rates for the over 65s were 72.37%, and at risk groups 51.21%. These were also comparable to CCG and national averages.

Good

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Appointments for tests and then for further review once the results were known were booked at the same time to ensure health assessments and checks were followed up.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

All of the 45 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with two members of the patient participation group (PPG) on the day of our inspection. They 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 July 2015 showed that the practice was rated higher than the national average for GP satisfaction but below average for nursing satisfaction. For example:

- 91.8% said the GP was good at listening to them compared to the CCG average of 87.3% and national average of 88.6%.
- 89.9%said the GP gave them enough time compared to the CCG average of 83.7% and national average of 86.8%.
- 97.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.2% and national average of 95.3%.
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 82.8% and national average of 85.1%.
- 80% patients said they found the receptionists at the practice helpful compared to the CCG average of 83% and national average of 87%.
- 73.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85.9% and national average of 90.4%.
- 74.6% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 88.1% and national average of 91.9%.
- 93.1% said they had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 95% and a national average of 97.2%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey were positive for questions about patient involvement in planning and making decisions about care with doctors, but were below average for this area regarding nurses. For example:

- 87% say the last GP they saw or spoke to was good at explaining tests and treatments compared with a CCG average of 84% and a national average of 86%.
- 89% say the last GP they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 79% and a national average of 81%.
- 80% say the last nurse they saw or spoke to was good at explaining tests and treatments compared with a CCG average of 85% and a national average of 90%.
- 68% say the last nurse they saw or spoke to was good at involving them in decisions about their care compared with a CCG average of 80% and a national average of 85%.

We spoke to the GP leads about nursing satisfaction ratings overall. They told us that nursing provision has been under review and increased capacity, training and appointment of additional staff such as a health care assistant will provide improve patient satisfaction in regard to nursing.

Good

Are services caring?

Staff told us that translation services were available both face to face and over the phone for patients who did not have English as their first language. We saw notices in the reception area informing patients of the translation service and there was an electronic self-check in screen that also had a choice of languages.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. There were seventy five carers on the practice register. The practice was taking action to increase the number of people on the register to 10% of the practice list in line with the 2011 population census findings. Carers were being supported by being told about their entitlement to a Carers Assessment by social services and by being given the practice's carers guide which signposted them to other sources of support, for example the Barnet Carers Association who operate a hub from the premises and branches of MIND, Age Concern, Alzheimer's Society and Citizens Advice Bureau. We saw that carers were offered priority appointments and were offered the flu vaccination.

Staff told us that if families suffered bereavement, their registered GP contacted them, by phone to offer condolence and offer support. Staff told us that patients on the palliative care register were given the GP's private mobile number, which they had 24 hour access to and confirmed that they found this useful, particularly in regard to respecting the cultural beliefs of the practice's Jewish population when a patient passes away and the need for a burial with no undue delay.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, in regard to antibiotic prescribing.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- There were longer appointments available for people with complex needs such as learning disability or mental health problems.
- There are 'commuter clinics' available through extended hours on a Thursday morning and Friday morning and evening and on Saturday mornings.
- Home visits were available for older patients / patients who would benefit from these.
- Nursing homes and specialist care provision for example The local Jewish school for children with learning disabilities under the practice's care each had a named GP to provide continuity for the staff and people's families.
- In addition to extended hours appointments there were telephone consultations and email access, online bookable appointments and an electronic prescribing service (EPS), and the over 40s health check to meet the needs of working age people. Online access for pathology results and medical summaries.
- A nurse for COPD and Asthma patients also provides smoking cessation support for this vulnerable group.
- Young person's clinic promoting sexual health, smoking cessation and engagement with children with chronic diseases.
- There is Alcohol support nurse available monthly for patients to be referred to
- Baby clinics run by Health Visitors are run weekly
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, including a ramp at front of building for wheelchair users and for prams and buggies, two disabled toilets, low level access at reception, loop system for hearing impaired, and new electronically adjustable examination couches.
- The practice was planning to install a lift to improve access.
- 24 hour GP access to support patients who required a Jewish burial which is often required with 24 to 48 hours of death.

Access to the service

The practice is open between 8.30am and 6.30pm Monday to Friday. During times of closure patients were directed to an out of hours provider. Extended hours surgeries were offered on Thursday morning from 7.30am to 8.30am, Friday morning 7.15am to 8.00am, Friday evening 6.30pm to 7.00pm and Saturday mornings 9.15am to 12.15pm. In addition to pre-bookable appointments that could be booked up to eight weeks in advance, urgent appointments were also available for people that needed them. There was a duty doctor every day who triaged patients to identify those who needed a home visit or to be seen urgently.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages. For example:

- 74.8% of patients were satisfied with the practice's opening hours compared to the CCG average of 68.7% and national average of 75.7%.
- 76% patients said they could get through easily to the surgery by phone compared to the CCG average of 63.4% and national average of 74.4%.
- 70.7% patients described their experience of making an appointment as good compared to the CCG average of 67.7% and national average of 73.8%.
- 70.5% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57.4% and national average of 65.2%.

We spoke to patients on the day of our visit and they told us that although they could get an appointment it was not often with their preferred GP and this was reflected in the national patient survey with 44.5% of patients usually getting to see or speak to that GP compared to a CCG average of 55.8% and national average of 60.5%. We spoke to the lead GPs about this feedback they told us they were continuously looking at how to improve access for patients to see or speak their preferred GP including potential use of telephone triage and other patient access approaches. GPs told us that the PPG would be vital in ensuring that access remains a priority and continues to meet the needs of patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice and a lead GP for complaints. We saw that information was available to help patients understand the complaints system. There was a poster in the reception area. Patients we spoke with were aware of the process to follow if they wished to make a complaint, but had not had occasion to complain.

We looked at thirteen complaints received in the last 12 months and found they were dealt with in a thorough, open and timely way. The practice held regular complaints meetings and staff told us that it was a shared learning experience. We saw that where possible, the practice took action to prevent the complainant experiencing the same problems again. For example, we noted one complaint in regard to a prescribing request error. We noted that the error was corrected and the patient was contacted in a timely fashion. We saw that a clinical meeting took place to discuss the significant event and an appropriate process was put in place to ensure that prescription directions from hospitals were appropriately dealt with and discussed with patients during a medication review.

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 which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice's aims were clear and reflected in their statement of purpose.

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. For example there were lead GPs for clinical governance, significant events, medicines management, QOF, information governance, safeguarding, GP training, minor surgery, learning disability, mental health., long term conditions and complaints.
- Practice staff were supported to carry out their roles and responsibilities.
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty and at the heart of its ethos was building resilience. Partners were visible leaders in the practice and staff told us they were approachable, supportive and would be receptive to any concerns or difficulties they had. Staff felt respected and valued, they told us it was a happy place to work and they understood the role they played in delivering services to patients.

Staff told us that regular team meetings were held and we saw a number of team meeting minutes across the practice for both clinical and non-clinical staff. Minutes showed these meetings were an effective means of sharing information and learning enabling the practice team to work together to respond to individual patients' and families' needs, improving outcomes for its patients. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team building opportunities were regular and held a few times a year. 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, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints and suggestions received. There was a virtual PPG in place with over 750 members; information was shared and issues discussed, for example most recently the practice gathered feedback on how it could reduce the number of patients who do not attend appointments. In recent years, the PPG had carried out patient surveys and submitted proposals for improvements to the practice management team. For example, suggestions included a water machine, 15 minute appointments, and the blood pressure machine and phlebotomy service all of which were introduced.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes

Are services well-led?

Good

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

to improve outcomes for patients in the area. The practice had recently submitted a bid application to NHS England to create an elderly medical multidisciplinary care hub within the practice which would include a lift, an X-ray room, physiotherapy, Occupational Therapy, and team education.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the proper and safe management of medicines because there were no patient group directions in place for the practice nurse who had been prescribing vaccinations to adults and children without approval. Regulation 12(2)(g).

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that recruitment procedures were not operated effectively to ensure that persons employed were of good character and have the qualifications, competence, skills and experience necessary for the role to which they were employed. A recently appointed member of non-clinical staff has been appointed to their role without proof of identify or complete reference checks, Regulation 19(3)(a)(b).