Lane End Medical Group

Quality Report

2 Penshurst Gardens
Edgware
HA8 9GJ
Tel: 0208 958 4233
Website: www.laneendmedicalgroup.co.uk

Date of inspection visit: 16 October 2014
Date of publication: 11/06/2015

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 Lane End Medical Group on 16 October 2014. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing effective, caring and well led services. We rated the practice as requires improvement for providing services for older people, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, people experiencing poor mental health (including people with dementia) and for people with long term conditions. It required also improvement for providing safe and responsive services.

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

- During our inspection, we observed that reception staff treated patients with dignity and respect;
- The practice had recognised the needs of different groups in the planning of its services. For example, a receptionist outlined the steps taken to help vulnerable patients who needed additional support to understand and be involved in their care;
- Records showed the practice used significant events to improve the service and we noted that learning points were shared at team meetings. However, we also found that learning outcomes from complaints received were not always shared with staff;
- We saw evidence that clinical audits were being used to help improve patient outcomes but noted the absence of a systematic clinical audit programme;
- The practice participated in a national performance measurement tool called Quality Outcome Framework (QOF). We saw that performance was above the Barnet and England practice average in a number of clinical areas such as dementia, coronary heart disease and childhood immunisations.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels of the organisation. This was supported by GPs' involvement in part time undergraduate, post graduate teaching and by nurse practitioner involvement in a local practice nurse mentoring scheme.

We saw evidence of outstanding practice:

- GPs had experience of contributing to child protection hearings in person or by submitting reports.

However, there were areas of practice where improvements were needed. Importantly, the provider must:

• Carry out Disclosure and Barring (DBS) checks on all staff who undertake chaperone duties at the practice.

In addition, the provider should;

- Ensure that learning outcomes from all complaints are identified and shared;
- Introduce a timetabled policies and procedures review programme to ensure they are fit for purpose;
- Ensure that the necessary locum GP pre-employment checks have taken place and are on file (for example we noted that a record of Hepatitis B vaccination status was not on file for one of the locum GPs).
- Continue working with its Patient Participation Group to make further telephone access improvements.

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. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses including safeguarding concerns. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients and staff were assessed and well managed including infection prevention and control audits. There were enough staff to keep people safe. Disclosure and Barring Service (DBS) checks had not been carried out for non clinical staff undertaking chaperone duties and there was no evidence that this decision was based upon a written risk assessment.

Are services effective?

Good

The practice is rated as good for providing effective services. Data we looked at before our inspection showed that patient outcomes were at or above average for the locality. Dementia (specifically diagnosis and care planning), coronary heart disease (unplanned hospital admissions) and heart rhythm disorder (stroke risk assessment) were better than the averages for practices in Barnet and England. However we also noted that the practice performed worse than these averages on aspects of diabetic care, including the number of newly diagnosed patients who had been referred to an education programme within nine months and the number of diabetic patients who had had a dietary review in the last twelve months.

Peoples' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams and used guidance from the National Institute for Health and Care Excellence (NICE) to improve patient outcomes. We saw evidence that clinical audits were being used to help improve patient outcomes but noted the practice lacked a systematic programme of clinical audits.

Are services caring?

Good

The practice is rated as good for providing caring services. Patient satisfaction was higher than other Barnet practices regarding helpfulness of reception staff and patients' involvement in decisions about their care. Patients told us they were treated with compassion, dignity and respect. A receptionist explained how they and reception colleagues helped patients requiring additional

Summary of findings

support to understand and be involved in their care. Patients we spoke with told us that the doctors and nurses provided sufficient information to be able to make informed decisions about their care and treatment. We saw that staff treated patients with kindness and respect and maintained confidentiality. The patient waiting areas were separated from the main reception to maximise patients' privacy.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. The practice had good physical facilities (such as wheelchair access, baby changing facilities) and was well equipped to treat patients and meet their needs. For example, longer appointments were offered for those that needed them and we saw that language interpreting (including British Sign Language) was available. Urgent same day appointments were available but not usually with a named GP.

The practice worked with three other local practices to provide a Monday- Friday afternoon urgent appointment service. We were told that the service gave patients access to a wider number of clinicians; therefore allowing the practice's clinical team to be more responsive to the ongoing care needs of patients with long term conditions or who were housebound.

Information about how to complain was available and easy to understand and we saw evidence that the practice responded quickly to issues raised. For example, PPG members told us that the practice waiting area had been redesigned based upon their feedback. We also saw some evidence that the practice learned from complaints and used this information to improve the service.

Patient feedback from the NHS England 2014 national GP patient survey, practice complaints and comment card feedback all highlighted patient dissatisfaction with the practice telephone system. When we spoke with the Chair of the practice's Patient Participation Group, they told us that the practice had acted upon the group's immediate concerns and that it was currently monitoring phone performance.

Are services well-led?

Good

The practice is rated as good for being well-led. There was clear leadership and staff told us they felt supported by management. The practice also had a clear vision and staff explained how their roles and responsibilities contributed to this vision. We were told that the patient list size had grown by approximately 25% in the past six years and the practice attributed this to the quality of care and facilities provided.

Summary of findings

The practice had a number of policies and procedures to govern activity and we noted that the GP partners undertook lead roles such as safeguarding and significant events. There were also systems in place to monitor and improve quality including regular meetings where patient outcomes performance was reviewed and action plans developed as necessary. Systems were also in place to identify risk (for example a legionella risk assessment took place in June 2014). We noted that the practice proactively sought feedback from patients and the PPG Chair gave examples of how the practice acted on the group's feedback. There was a strong focus on continuous learning and improvement at all levels of the organisation. Clinicians undertook part time undergraduate teaching, post graduate teaching and nurse mentor roles; and staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance (including the Mental Capacity Act 2005). Nationally reported data showed that the practice performed better than the Barnet and England average for assessment of conditions commonly found in older people such as dementia. The number of dementia care reviews that had taken place in the last 15 months and seasonal flu vaccination for patients aged 65 and older were also above average.

We noted that the practice was responsive to the needs of older people offering, for example home visits, rapid access appointments and extended appointment slots. Older patients spoke positively about how they were treated by staff and we noted that they were well represented on the Patient Participation Group. Patients aged over 75 had their own named GP and were offered annual health checks.

Records showed that the practice routinely reviewed the care of patients on its palliative care register and that it worked with palliative care nurses in the care and treatment of patients.

The provider is rated as good for providing effective, caring and well led services; and this includes for this population group. The provider is rated as requires improvement for providing safe and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. We noted that 54% of patients had a long standing health condition and the practice outlined how it worked to improve outcomes. For example, we were told that longer appointments and home visits were available when needed. Patients had a named GP and practice nurses regularly reviewed patients on long term condition registers to check that their health and medication needs were being met. Patients with long term conditions told us that clinicians provided sufficient information to enable them to make informed decisions about their care and treatment.

Summary of findings

We noted that QOF performance data was routinely used at weekly clinical meetings to monitor and review patient outcomes. We also saw evidence of how practice staff worked with other health care professionals such as district nurses to deliver a multidisciplinary and coordinated package of care.

We noted that QOF performance on aspects of a range of long term conditions such as dementia (specifically diagnosis and care planning), coronary heart disease (unplanned hospital admissions) and heart rhythm disorder (stroke risk assessment) were better than the averages for practices in Barnet and England.

The provider is rated as good for providing effective, caring and well led services; and this includes for this population group. The provider is rated as requires improvement for providing safe and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. Immunisation rates at 12 months, 24 months and 5 years were better than the average for Barnet practices. Appointments were available outside of school hours and the premises were suitable for children and babies (for example baby changing facilities were available). Records showed that the practice worked closely with midwifes and school nurses and that a children at risk register was kept and regularly reviewed. Practice staff were aware of local safeguarding contacts and knew how to escalate concerns. The practice also ran a drop in sexual health clinic which was particularly responsive to the needs of young patients. Practice nurses specialised in women's health and contraception.

The provider is rated as good for providing effective, caring and well led services; and this includes for this population group. The provider is rated as requires improvement for providing safe and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included, telephone consultations, early morning appointments and also online appointment booking and repeat

Summary of findings

prescriptions facilities. However, some patients gave feedback that it was difficult to get through to the practice by phone. The practice offered a full range of health promotion and screening that reflected the needs of this age group. Health promotion material was available throughout the practice including via a TV in the patient waiting area. The practice's website contained links to NHS Choices healthy living advice webpages.

The provider is rated as good for providing effective, caring and well led services; and this includes for this population group. The provider is rated as requires improvement for providing safe and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances. Patients with a learning disability were offered annual health checks and longer appointments. We also noted that "easy read" pictorial leaflets were available, outlining various treatments and conditions.

Staff knew how to recognise signs of abuse in vulnerable adults. They were also aware of their responsibilities regarding information sharing, documenting safeguarding concerns and contacting relevant agencies in normal working hours and out of hours. The practice offered interpreting services in a range of languages including British Sign Language (BSL).

We noted that 19% of patients had a caring responsibility (above the England average) and were advised that the practice signposted patients requiring support to a local carer support network. We also noted that carers information was provided in the practice reception and on the practice website.

The provider is rated as good for providing effective, caring and well led services; and this includes for this population group. The provider is rated as requires improvement for providing safe and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice kept a register of patients experiencing poor mental health and GPs

stressed the importance of reviewing patients' physical as well as mental health. We noted for example that the practice performed slightly better than the Barnet average for a record of a blood pressure check on file in the preceding twelve months.

The practice offered flexible appointments such as evening appointments (when the practice was less busy) as we were told that this was preferred by many patients experiencing poor mental health. The practice also had systems in place to support patients presenting with acutely poor mental health and also routinely signposted patients with less severe symptoms to specialist local voluntary sector organisations. We noted that the practice's QOF performance was better than the Barnet and England averages for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis.

The provider is rated as good for providing effective, caring and well led services; and this includes for this population group. The provider is rated as requires improvement for providing safe and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

What people who use the service say

During our inspection, we spoke with seven patients who were generally positive about the care and treatment they received and with the practice environment. One of the patients was also the Chair of the practice's Patient Participation Group (PPG) and gave examples of how the practice had acted upon patients' concerns.

We also reviewed 31 patient comment cards. These had been completed by patients in the two week period before our inspection and enabled patients to record their views on the practice. Feedback was also generally positive with key themes being that staff were respectful, that they listened and that they were compassionate. However, some patients also expressed concern that it was difficult to get through to the practice by telephone.

We used existing patient feedback to guide our discussions with patients. For example, the NHS England GP national patient survey 2014 highlighted that only 31% of respondents found it easy to get through to the practice by phone (worse than the average of 63% for Barnet practices). The practice also conducted its own annual patient survey in February 2014 (21 patients) and we noted that patients highlighted telephone access as the main area requiring improvement. Nearly half of the 21 patient complaints received for the latest available period (2013/14) related to telephone access. However, during our inspection we saw evidence of how the practice was working with its PPG to improve the telephone system.

Patients told us that they felt involved in decisions about their care and treatment and that their questions were answered. This was consistent with NHS England GP national patient survey 2014 which highlighted that 93% of respondents felt their GP was good at listening to them (compared with the Barnet practices average of 87%).

Areas for improvement

Action the service MUST take to improve

- Carry out Disclosure and Barring (DBS) checks on all staff who undertake chaperone duties at the practice

Action the service SHOULD take to improve

- Ensure that learning outcomes from all complaints are identified and shared;
- Introduce a timetabled policies and procedures review programme to ensure they are fit for purpose;
- Ensure that the necessary locum GP pre-employment checks have taken place and are on file (for example we noted that a record of Hepatitis B vaccination status was not on file for one of the locum GPs).
- Continue working with its Patient Participation Group to make further improvements to telephone access.

Outstanding practice

- GPs had experience of contributing to child protection hearings in person or by submitting reports.

Lane End Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP, practice nurse and practice manager specialist advisors. They were granted the same authority to enter the registered person's premises as the CQC lead inspector.

Background to Lane End Medical Group

Lane End Medical Group is located in Barnet, North London. Public Health England's Barnet 2014 Health Profile notes that the health of people in Barnet is generally better than the England average. Deprivation is lower than average, however about 19.9% (14,200) of children live in poverty. Life expectancy for both men and women is higher than the England average.

By the time children reach age ten, 19.1% (559) are classified as obese. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are better than the England average.

The rate of smoking related deaths, estimated levels of adult excess weight and smoking are all better than the England average. The rate of Tuberculosis is worse than average as is the rate of statutory homelessness. Rates of new cases of malignant melanoma, drug misuse, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

In Barnet, strategic improvements in health and wellbeing are led by the borough's Health & Wellbeing Board; comprised of Barnet Council, Barnet CCG, Barnet Healthwatch and other health stakeholders. Priorities in Barnet include increasing rates of physical activity, supporting self-care, supporting people with mental health problems back into work and giving children a healthy start.

Lane End Medical Group has a patient list of approximately 11,500 (above the England and Barnet average). Fourteen percent of patients are aged 65 or older and 20% are under 18 years old. Forty eight percent have a long standing health condition and 16% have carer responsibilities. Approximately 24% of patients are from Black and minority ethnic groups.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions and smoking cessation clinics. The staff team comprises seven GP partners (four female, three male), three salaried doctors (two female, one male), one nurse practitioner, two practice nurses (all female), two health care assistants (one female, one male), practice manager and a range of administrative staff.

The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients.

The CQC intelligent monitoring placed the practice in band three. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands,

with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

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.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 16 October 2014. During our visit we spoke with a range of staff (GPs, nurse practitioner, practice nurse, practice manager, office manager and reception staff) and spoke with patients who used the service including PPG members. We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients shared their views and experiences of the service.

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

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

We also looked at how well services 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety including reported incidents and comments/complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, the practice nurses' outline of how they would report a sharps injury was consistent with the practice's infection control and prevention policy. The practice also had a safety alert protocol detailing the procedure for sharing received drugs alerts throughout the practice. Staff knew their roles and accountability in this process. There were effective arrangements in place to report safety incidents in line with national and statutory guidance.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at five events recorded since May 2014. They included a record of the area of concern, staff learning points, key actions and further review. For example, following an incident where a GP request to replace an expired emergency drug had not been actioned, therefore resulting in a patient being administered an out of date drug; the practice had improved systems for checking expiry dates and replacing drugs. However, we noted that the significant events recorded did not have an assigned level of risk.

Records showed that significant events were discussed at weekly clinical meetings and that every two months a more detailed analysis took place led by a designated partner GP and practice nurse. The GP also had responsibility for sharing learning amongst staff; including helping staff to understand and fulfil their responsibilities to raise concerns and report incidents or near misses.

Records showed how the practice used significant events to improve the service and we also noted that learning points from events were shared at wider, administrative staff team meetings. However, we also saw that some complaints received related to patient safety (for example delayed patient referral letters) but that there was no evidence of learning outcomes from these being shared with staff.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. A senior GP was designated safeguarding lead and the practice had ensured all staff were trained in protecting vulnerable adults and children from abuse to the appropriate level. For example, GPs and nurse practitioners were Level 3 trained in child protection and had also received vulnerable adults safeguarding training. non clinical staff had attended basic children and vulnerable adults safeguarding training. Staff were able to recognise types of abuse (including in older patients) and knew how and to whom they would report or escalate a concern. The practice had policies for child protection and at risk adults which included local authority and CCG contact details. Staff were aware of these contacts and GPs had experience of contributing to child protection hearings in person or by submitting reports. Practice nurses were in regular contact with the borough's health visitors.

The practice had a chaperone policy and we were told that some administrative staff undertook chaperoning duties. However, these staff had not undergone Disclosure and Barring Service (DBS) checks and there was no evidence that this decision was based upon a written risk assessment of their duties. Chaperone training had also not been provided.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients experiencing poor mental health.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures. This also included action to take in the event of a power failure. We noted that medicines refrigerator temperatures were recorded on a daily basis and were within the required parameters. The practice did not hold Controlled Drugs on the premises. Medicines were within their expiry date.

We saw evidence that the practice undertook medicines audits triggered by NICE guidance. For example, one audit of diabetic patients examined whether the dosage of a drug prescribed to regulate blood sugar levels was in

accordance with NICE guidance (when prescribed with other drugs). The audit identified 17 patients from 41 reviewed whose dosage could be reduced in accordance with the guidance; at a cost saving and with no impact on clinical effectiveness.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All clinical, communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment. Consultation rooms had vinyl flooring and we noted that clinical waste was stored securely away from patient areas whilst awaiting collection. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We looked at staff records and noted that with the exception of one locum GP, all clinical staff were up to date regarding Hepatitis B immunisation vaccination.

The practice's nurse practitioner was the Infection Prevention and Control (IPC) lead and responsible for ensuring effective infection control throughout the practice. Practice nurses had attended infection control training within the last twelve months. Personal protective equipment such as gloves and aprons were readily available for staff to use.

The practice had an infection control policy and we noted that in accordance with the policy, infection control audits took place every six months. We looked at the latest audit results (September 2014) and were able to confirm for example, that clinical waste was stored away from public and patient areas whilst awaiting collection. However, we also noted that the practice had not yet developed an action plan in response to improvement areas identified in the audit.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had also taken place in June 2014 and we noted that no issues had been identified.

Records confirmed the practice was carrying out regular checks in line with its legionella policy to reduce the risk of infection to staff and patients.

Equipment

We saw evidence of calibration of relevant equipment within the last twelve months including electronic blood pressure machines, weighing scales and defibrillator. We noted that one manual blood pressure monitor had failed testing and we were advised that it had been withdrawn from service. Fire alarm and portable appliance testing (PAT testing) had also taken place within the last twelve months.

Staffing & Recruitment

The practice had systems in place to ensure that staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had recruitment procedures in place that ensured staff were recruited appropriately. The majority of staff had been employed by the practice for more than ten years. Disclosure and Barring Service (DBS) background checks were on file for clinical staff but not for some non clinical staff undertaking chaperone duties. We noted that new staff completed an induction which included infection control & prevention, health and safety and an overview of staff members' roles.

Staff told us there were usually enough staff to maintain the smooth running of the practice and we saw evidence that systems were in place to keep patients safe.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual, bi-annual and monthly checks of the building and equipment, infection control, medicines management, staffing and dealing with emergencies. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk and records showed that identified risks were routinely discussed at clinical meetings.

Arrangements to deal with emergencies and major incidents

There were sufficient systems in place to deal with a medical emergency. The practice had an automated external defibrillator, emergency medicines and emergency

Requires improvement

Are services safe?

oxygen. These were within expiration and we noted that an allocated nursing staff member undertook regular checks. Clinical staff had received cardiopulmonary resuscitation (CPR) training within the last twelve months. Non clinical staff had received CPR training within the last three years.

Plans were in place to respond to emergencies and major situations. The practice had a business continuity plan which described to staff what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure, and contained relevant contact details for staff to refer to (such as support numbers in the event of an electrical power failure). If the practice had to close urgently, there was a reciprocal arrangement in place with a nearby practice which used the same clinical system, therefore minimising disruption. The plan had been reviewed in the last twelve months and we noted that staff understood their roles and responsibilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure that patients' care and treatment was assessed, planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This included use of Quality and Outcomes Framework (QOF- a national performance measurement tool). For example, QOF data showed that the practice performed better than the Barnet and England averages for arthritic patients aged 30-84 who had had a cardiovascular risk assessment in the preceding twelve months. Regular cardiovascular checks for arthritic patients are identified as best practice by the National Institute for Health and Care Excellence (NICE). We also noted that at 81% the practice performed better than the Barnet practice average (60%) and England practice average (58%) for newly diagnosed patients with depression who had had a follow up review within the target 35 days.

Clinicians undertook part time undergraduate teaching, post graduate teaching and nurse mentor roles; and staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice. Weekly clinical meetings included discussions on changes to guidance and best practice including National Institute for Health and Care Excellence (NICE).

GPs led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Two of the partner GPs had published nationally recognised research on prevention of breast cancer and they and other GPs undertook part time undergraduate and post graduate medical teaching. The practice's nurse practitioner trained student nurses in primary care as part of a Community Education Provider Network initiative to improve nurse training in primary care. These activities supported staff in continually reviewing, discussing and sharing clinical best practice.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients including data input, scheduling clinical reviews, managing child protection alerts and medicines management. Information was collated by the practice manager and used to support the practice's clinical audits.

Information about patient's care and treatment, and their outcomes, was routinely monitored and information used to improve care. For example, weekly clinical meetings included a review of palliative care (end of life) patients and children in need.

We saw evidence of four clinical audits that had taken place in the last twelve months and noted that two of the audits were ongoing. The completed audits evidenced how audit results were used to improve patient outcomes and were typically linked to new clinical guidelines or safety alerts. For example, one audit assessed the regularity of six monthly blood tests for patients with a repeat prescription for Carbamazepine (a drug used in the treatment of bi polar disorder). We noted that the second phase of the audit had identified a small increase in six monthly blood tests and that it recommended improvements in patient education and patient recall arrangements to further continue this trend. Senior GPs told us that the practice's recent transition over to a new clinical system had hindered development of clinical audits but that clinical audits were now a key priority.

The practice performed better than the England practice average in a number of Quality and Outcomes Framework (QOF) clinical targets for the year ending April 2014 including occurrence of regular (at least three monthly) multidisciplinary review meetings where all patients on the practice's end of life care register were discussed.

We also noted that the practice performed better than the England average regarding childhood immunisations. For example, 94% of eligible infants up to twelve months had received their "5-in-1" vaccine to boost protection against five childhood diseases including tetanus and whooping cough. This compared with the Barnet practice average of 78%. We also noted that at 94%, practice performance on children up to age five having received a 5-in-1 booster was better than the Barnet practice average (91%).

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date regarding mandatory training (for example safeguarding). We noted a good skill mix amongst the GPs and also noted a mixture of female and male GPs. We noted that GPs were up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had completed annual appraisals within the last 12 months where performance was reviewed and training needs identified. They told us that although formal supervision meetings did not take place, they felt supported in their roles.

We noted that the practice had recently joined a local GP federation with three other practices to provide a week day afternoon urgent appointments service. This entailed an initial patient telephone assessment, a telephone appointment with a GP (jointly employed by the four practices) and a subsequent appointment at any of the four practices. Lane End Medical Group GPs spoke positively about how the service had freed up clinical resources to enable the nursing team to deliver ongoing chronic disease management and to enable GPs to undertake home visits to the practice's large frail, housebound population.

Working with colleagues and other services

The practice had systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. For example, records showed that regular meetings took place with district nurses, health visitors and end of life nurses to monitor and review patient care and treatment. Minutes of clinical meetings showed that clinicians were regularly invited to attend practice clinical meetings. Systems were also in place to signpost or refer patients to specialist third sector agencies including mental health and carer support.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. When we reviewed the system we saw that patients were referred in a timely manner and that all the information needed for their ongoing care was shared appropriately.

We also noted that incoming correspondence was processed in a timely fashion. However, there was no formal audit system in place to assess the completeness of records and identify action to be taken where necessary.

Consent to care and treatment

Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005. Systems were in place to support patients to make decisions including where appropriate, an assessment of their mental capacity. Systems were also in place for situations where patients lacked the mental capacity; ensuring that 'best interests' decisions were made and recorded in accordance with legislation.

We also noted that clinical staff demonstrated a clear understanding of Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

One of the partner GPs sat on the board of Barnet CCG and we were told that the practice worked closely with the CCG to share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area and is used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. We noted that a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. The practice also offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Latest available performance data for immunisations at twelve months, twenty four months and five years was above the average for Barnet practices. We also noted that seasonal flu vaccination rates for patients over 65 was slightly better than the national average; as were dementia diagnoses rates.

However, we also noted that at 70%, practice performance was below the Barnet practice average (87%) on newly diagnosed diabetic patients who had been referred to an education programme within nine months. In addition, at 63%, practice performance on the percentage of diabetic

Good

Are services effective?

(for example, treatment is effective)

patients who had had a dietary review in the last twelve months was below the Barnet practice average (86%). Practice data on women who had had cervical screening within the last five years (69%) was also below the averages for Barnet and England practices (respectively 74% and 77%).

We noted that the reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Before our inspection, we noted NHS England 2014 national GP patient survey feedback that 84% of respondents found receptionists helpful. When we spoke with patients they were positive about how they were treated by reception staff and during our inspection we observed that reception staff treated patients with dignity and respect. When we spoke with a receptionist they stressed the importance of seeing a patient as an individual. Patients we spoke with were also positive about how they were treated by GPs and nurses; and we noted that this was consistent with comment card feedback. The NHS England 2014 national GP patient survey fedback that 94% of respondents said that the last nurse they saw or spoke to was good at treating them with care and concern.

The practice offered a chaperone service which was publicised in reception. Reception staff undertook chaperone duties but had not received training.

NHS England 2014 national GP patient survey also reported that 52% of patients were satisfied with levels of privacy in reception (better than the Barnet average). During the inspection, we observed that the reception area was located away from the two waiting areas and that conversations between the receptionist and patients could not be overheard. Privacy in reception was not identified as an issue in any of the 31 comment cards we looked at or in PPG feedback. Additionally, none of the 36 respondents to the practice's 2014 patient survey mentioned privacy as an area of concern.

Care planning and involvement in decisions about care and treatment

The NHS England 2014 national GP patient survey reported that 81% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments (better than the Barnet practice average). Patients told us that they felt involved in decisions about their care and treatment and this was also a consistent theme of comment card and survey feedback. For example, the survey reported that 76% of respondents felt their GP had involved them in decisions about their care (better than the Barnet practice average).

The practice's QOF performance was also better than the national average for the percentage of patients who had a documented comprehensive care plan on file, agreed between individuals, their family and/or carers as appropriate.

The practice website and reception contained a range of information to help patients make informed decisions about their care and treatment. A receptionist outlined to us the steps that she and her colleagues routinely undertook to help patients who needed additional support to understand and be involved in their care.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website advised people how to access local and national support groups and organisations. 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, 84% of respondents fed back that the last GP they saw or spoke to was good at treating them with care and concern(better than average). This was consistent with face to face and comment card feedback which highlighted that staff responded compassionately and provided support when required such as during times of bereavement or prolonged treatment.

The practice signposted patients to organisations providing specialist support such as cancer and diabetes support. Records also showed that end of life care nurses regularly attended multi-disciplinary meetings at the practice to ensure that emotional support and caring support were coordinated. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked.

We noted that 19% of patients had a caring responsibility (above the England average). We were advised that the practice routinely signposted patients to a local carer support network and we noted that carers information was provided in the practice reception and on the practice website. The practice QOF performance was better than the Barnet and England averages for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a range of appointment options to meet the needs of its patient groups including appointment booking by phone, online or in person. Early morning appointments were available on Monday and Tuesday mornings (7.30am). Late evening openings were available on Mondays (7.30pm). The practice provided a named GP and extended appointment slots for patients aged over 75 years or who had a learning disability. Home visits were also available as well as telephone consultations. There had been very little turnover of staff during the last five years which enabled good continuity of care.

The practice also offered a range of clinics to meet the needs of its patient groups including ante natal clinics, sexual health clinics and smoking cessation. Targeted activity took place such as a seasonal "drop in" flu clinic for patients aged sixty five and over; and we noted that QOF performance on this indicator was better than the England average.

The practice was aware of its population group profile and used QOF to respond to patient need and improve outcomes. For example 22% of patients were under 18 and we noted that the practice employed two practice nurses, one nurse practitioner and two health care assistants to deliver care to this (and other) population groups. Child immunisation rates were better than the average for Barnet and England.

We noted that 54% of patients had a long standing health condition and the practice was able to demonstrate how QOF performance data was used to respond to patient need and improve outcomes. We noted that unplanned hospital admissions related to coronary heart disease were significantly less than the average for Barnet and England. However we also noted that some aspects of diabetic care were below the averages for Barnet and England.

We noted that 16% of patients were aged 65 or over (which reflected Barnet's relatively older population). The practice also demonstrated how it used QOF data to work towards improving patient outcomes for older people. For example, at 73.4% seasonal flu vaccination rates were slightly above the Barnet practice average of 73.2%.

Information about the needs of patients using the service was used to inform how services were planned and delivered. The practice had an active Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice). The chair of the PPG spoke positively about how the groups' views were taken on board. For example, following PPG feedback the practice had replaced the main switch board "0845" number with a local "0208". We were also advised that the practice was producing information to educate patients on the role of the practice's nurse practitioner. A nurse practitioner is an advanced practice registered nurse who has completed advanced coursework and clinical education and is qualified to diagnose medical problems, order treatments, prescribe medications and make referrals. The group had an action plan which identified the above and other areas for improvement with time scales.

Tackling inequity and promoting equality

The practice was purpose built and had ramped access to allow patients with mobility scooters and wheelchairs to access the practice. Toilets were wheelchair accessible and contained baby changing facilities. The waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the consultation rooms. There was a hearing loop at reception for patients with a hearing impairment and the practice made use of an interpreter service (including British Sign Language interpreters) to ensure patients whose first language was not English could access the service. Records showed that staff had completed equality and diversity training. The reception desk included a lowered section to enable ease of access for wheelchair users and children. We noted that the practice web site was available in local community languages such as Hebrew, Polish and Somali. We did not see evidence of translated materials in reception such as the practice complaints policy or new patient information leaflet.

The practice had recognised the needs of different groups in the planning of its services. The practice offered extended appointments and "easy read" pictorial leaflets for patients with learning disabilities. A receptionist outlined the steps that she and reception colleagues routinely undertook to help patients who needed additional support to understand and be involved in their care. We also noted that a range of support was offered to carers including signposting to a local carers support network.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Annual health checks were provided for patients who experienced poor mental health and we saw that the practice's QOF performance on cervical screening test of women experiencing poor mental health was slightly above the Barnet average. The practice also offered flexible services and appointments including for example, evenings appointments (when the practice was less busy) as this was preferred by many patients.

The practice provided text appointment reminders to all patients which we noted was of particular support to patients with a hearing impairment or who were living with dementia. A screen with the name of the next patient to be seen was located in reception which was responsive to the needs of patients with a hearing impairment.

Access to the service

Appointments were available from 7.30am - 7.30pm on Mondays and Tuesdays; and 8:30am to 6:30pm Wednesday to Friday.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments online. An on line repeat prescription facility was also available.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. This was also detailed on the website.

Longer appointments were available for people who needed them such as patients with a learning disability and those with long-term conditions. Patients over 75 had a named GP although some patients aged over 75 told us that they did not always see their GP; particularly if the appointment was at short notice. Home visits were made to those patients who needed one.

We noted that the practice had recently entered into a collaborative arrangement with three other practices to provide an afternoon urgent appointments service Monday to Friday from any of the four surgeries (venue rotated on a daily basis). The practice told us that the service enabled GPs and the nurse practitioner to deliver ongoing chronic disease management and to undertake more visits to its large frail housebound population. Patient feedback was generally positive regarding access although some of the comment card feedback expressed concern at appointments duration and at not seeing the GP of their choice. Some patients also expressed dissatisfaction with the practice phone system.

Survey feedback also showed dissatisfaction at accessing the practice by phone. For example, only 31% of respondents to the NHS England 2014 national GP survey fed back that it was easy to get through to this surgery by phone (compared to the Barnet average of 61%). The practice conducted an annual patient survey in February 2014 (21 patients) and this highlighted phone access as the main area for improvement. Some comment card feedback was also negative regarding phone access. The practice told us that they were aware of these concerns and that they were developing patient information on the best time to contact the practice and patient preparation for the call. We also noted that phone system review was included in the PPG action plan.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints to the practice.

We saw that information was available in reception and on the practice website to help patients understand the complaints system. This included advice on how patients could escalate complaints to the Health Service Ombudsman. Patients told us they were aware of the process to follow if they wished to make a complaint but had not needed to make a complaint about the practice. The provider may wish to note that the complaints section of the website was located on under "practice policies" and not easily located.

There was some evidence that practice reviewed complaints to identify themes or trends which could be used to improve the service. We looked at the latest available report (2013/14) and saw that ten of the twenty one complaints related to the introduction of an 0845 main switchboard number. We were told that in response, the practice had reverted back to its original 0208 number. Other complaints related to delays in referrals, patient confidentiality and records; and we saw how the practice had used this information to improve patient outcomes. We also noted however, that four complaints did not have an associated learning outcome.

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 good quality patient centred general practice. We spoke with a range of staff including reception staff, practice nurses, nurse practitioners and GPs; all of whom described a patient centred approach to delivering care. We did not see evidence of a business plan but discussions with staff and review of staff and clinical meeting minutes highlighted that the practice's focus was upon good quality patient centred care and treatment.

We were told that the patient list size had grown by approximately 25% in the past six years and the practice attributed this to the quality of care and facilities provided.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We also noted that partners undertook lead roles (for example on safeguarding, significant events). We looked at a range of policies including infection control, data protection and safeguarding.

Some policies we reviewed did not include a review date (for example the repeat prescription policy) and others were out of date (for example the practice's whistle-blower policy referenced Primary Care Trusts which were abolished in 2013).

We did not see a record confirming that staff had read the policies but staff generally demonstrated an understanding. For example, reception staff were aware of the practice's safeguarding lead and how to escalate a concern.

The practice undertook clinical audits and clinical meetings included discussions regarding clinical audits but we did not see evidence of a planned programme of clinical audit being systematically used to improve outcomes for patients. We noted that the practice's weekly clinical meetings included discussion about performance, quality and risk.

Leadership, openness and transparency

There had been very little turnover of staff during the last five years which enabled good continuity of care. Records showed that monthly team meetings took place and we saw that leadership issues such as senior staff changes were communicated. Staff told us that there was an open culture at the practice and that they felt comfortable raising issues at team meetings.

We saw evidence that senior GPs encouraged supportive relationships among staff so that they felt valued and supported. Staff team minutes showed that an "employee of the month" award had been introduced and that senior GPs funded staff social events. We also saw that the practice's significant events procedure was used to provide positive feedback to staff.

The service was transparent, collaborative and open about performance. Records showed that QOF performance was regularly reviewed and there was evidence that audits had been used to improve patient outcomes (such as for patients experiencing poor mental health).

Practice seeks and acts on feedback from users, public and staff

We saw evidence that the practice had acted on patient feedback from surveys, comment cards and complaints received. For example,

The practice's latest annual patient survey reported that 33% of respondents had rated telephone access as "poor" because the practice was using a more expensive 0845 number. As a result of this feedback and PPG feedback, the practice had reverted back to its original 0208 switchboard number. However, other than advising patients of the best times to phone the practice, it was unclear what changes had been made to the phone system in order to improve patient access.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups including people with long term conditions, older people and Black and minority ethnic communities. The PPG developed an annual action plan with the practice and we saw that this was in the process of being implemented. For example, phone performance was currently being reviewed.

The practice generally sought and received staff feedback at monthly team meetings and there was evidence that staff members' views were sought and acted upon. Staff told us they felt supported by partner GPs and informed and involved in decision making.

Are services well-led?

Good

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

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. For example, the practice trained student nurses in primary care as part of a Community Educator Provider Network initiative improving nurse training in primary care.

The practice was a teaching practice and we also noted that GPs undertook part time undergraduate and post graduate teaching. Staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice.

Significant events and complaints were discussed at monthly, non clinical staff team meetings to share learning and improve patient outcomes.

There was a strong focus on continuous learning and improvement at all levels of the organisation which was supported by GPs' involvement in part time undergraduate, post graduate, hospital consultancy and nurse education mentor roles. We were also advised that two of the partner GPs had published nationally recognised research on prevention of breast cancer.