The Speedwell Practice

Quality Report

The Health Centre,
Torrington Park
North Finchley
N12 9SS
Tel: 020 8445 7261
Website: www.thespeedwellpractice.nhs.uk/

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected The Speedwell Practice on 09 October 2014. This was a comprehensive inspection. Overall, we rated the practice as good.

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

Our key findings were as follows:

- The practice completed reviews of significant events and other incidents and there was evidence that these were used as learning points for clinical staff.
- Training records showed that staff were up to date regarding mandatory training such as safeguarding children and vulnerable adults. We also noted a good skills mix amongst the doctors. For example, some had undertaken further specialist training in sexual and reproductive medicine.
- Patients spoke positively about how they were treated by staff and we noted that this was consistent with comment card and patient survey feedback.
- The practice had an active Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice). Patients spoke positively about how their views were taken on board, highlighting for example recent changes to the reception area layout to improve patient privacy.
- The practice had clear leadership. Senior GPs saw the vision of the practice as to deliver good quality, patient centred care. We spoke with a range of staff including reception staff, practice nurses, nurse practitioner and GPs who all understood their roles and responsibilities in delivering this vision.

We saw outstanding practice:

Summary of findings

- On visits to care homes, GPs used a secure Wi-Fi computer connection to enable their lap tops to access the practice's clinical software system. Clinical records (including electronic prescribing) could be updated from the care homes as opposed to back at the practice. This enabled responsive and patient centred care.

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

- Use its monthly, non clinical staff team meetings to discuss significant events, complaints or share learning; to improve outcomes for patients.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses including safeguarding concerns. Lessons were learned and communicated to support improvement although we noted that significant events and complaints were only discussed at weekly clinical meetings and not at wider, monthly, non clinical staff team meetings. 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.

Are services effective?

Good

The practice is rated as requires improvement for providing effective services. Data showed patient outcomes were at or above average for the locality. For example, unplanned hospital admission rates for patients with diabetes were below the averages for practices in Barnet and England. 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 although not all meetings were minuted. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. We saw evidence that clinical audits were being used to help improve patient outcomes but also noted that some audits were incomplete.

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 care. Patients told us they were treated with compassion, dignity and respect. Information to help patients understand the services available was easy to understand and patients told us that this helped them to make informed decisions about their care and treatment. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. 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

Summary of findings

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.

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 evidence that the practice learned from complaints and used this information to improve the service.

Patient surveys highlighted dissatisfaction with the practice phone system. The practice told us that in response, a new phone system had been introduced. An online appointments and repeat prescription facility had also been added to the website in order to relieve pressure on the phone system. However, patients told us that they still experienced delays. We were advised that telephone access was regularly reviewed at patient participation group meetings.

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. The practice had a number of policies and procedures to govern activity and held regular governance meetings (for example regarding 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. There were systems in place to identify risk (for example regular infection control audits took place). The practice proactively sought feedback from patients and PPG members showed how the practice acted on their feedback. There was a strong focus on continuous learning and improvement at all levels of the organisation.

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. An example of outstanding practice was how the practice used web based clinical software when visiting patients at local care homes. For further information please refer to the 'outstanding practice' and 'detailed findings' sections of our report.

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 outcomes for patients were good for conditions commonly found in older people such as diabetes. 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.

Staff had received training on how to care for people with mental health needs and dementia. For example, the practice hosted GP dementia training delivered by the local mental health trust and we also noted that it performed better than the Barnet average for the number of dementia care reviews that had taken place in the last 15 months. Practice dementia diagnosis rates were better than the national average. Records showed that the practice routinely reviewed the care of patients on its end of life register and that it worked with end of life nurses in the care and treatment of patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. 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. We noted that unplanned hospital admission rates for patients with diabetes and coronary heart disease were lower than the practice averages for Barnet and England. Healthcare professionals such as health visitors and district nurses were based in the same building and we saw evidence of how practice staff worked with them to deliver a multidisciplinary package of care.

Summary of findings

Reception and other administrative staff attended Cancer Research UK cancer awareness training to develop their knowledge of key messages around cancer prevention and screening. We noted that the practice also treated new patient cancer diagnoses as significant events and reviewed the process to diagnosis to see if improvements to care and treatment could be identified.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates at 12 and 24 months were better than the average for Barnet practices. Senior GPs attributed this to a proactive nursing team and weekly "drop in" mothers and babies clinic where immunisations could take place. Appointments were available outside of school hours and the premises were suitable for children and babies (for example baby changing facilities were available). The practice hosted a range of mother and toddler support groups including for specific communities such as for Japanese mothers living at a local university halls of residence. Health visitors were based in the same building and we saw evidence of how this facilitated joint working with practice staff. The practice also worked closely with midwifes and school nurses. 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.

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a

register of patients living in vulnerable circumstances. 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. Some patients with a learning disability lived at a local care home. The manager spoke positively about how patients were treated by reception staff and about how clinicians explained treatments.

The practice also kept a register of patients at risk of or experiencing domestic violence. A recent review had resulted in an action plan aimed at improving patient disclosure rates. We saw that the action plan included clinical staff awareness training (covering for example additional questions to ask during a consultation and an outline of local domestic violence support agencies).

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice offered interpreting services in a range of languages including British Sign Language (BSL).

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).

The practice kept a register of patients experiencing poor mental health. GPs stressed the importance of reviewing patients' physical as well as mental health and we noted that the practice performed better than the England and Barnet averages for cholesterol checks in the last 12 months for patients with poor mental health.

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 routinely referred patients experiencing poor mental health to local voluntary sector organisations for specialist support.

Staff had received training on how to care for people with mental health needs and dementia. For example, the practice hosted GP dementia training delivered by the local mental health trust and we also noted that it performed better than the Barnet average for the number of dementia care reviews that had taken place in the last 15 months.

Summary of findings

What people who use the service say

During our inspection, we spoke with 21 patients who overall, were happy with the care and treatment they received and with the practice environment. Some patients were also members of the practice's Patient Participation Group(PPG) and gave examples of how the practice had listened and acted upon patients' concerns (for example the redesign of the patient waiting area).

We also reviewed 14 patient comments 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 uniformly positive with key themes being that staff were respectful, that they listened and that they were compassionate.

We used existing patient feedback to guide our discussions with patients. For example, the national GP patient survey 2014 highlighted that only 33% of the 312 respondents found it easy to get through to the practice by phone (worse than the average of 63% for Barnet practices). We were told that following PPG feedback, a new phone system had been introduced in addition to online appointments and repeat prescriptions facilities.

However, patients we spoke with expressed continued dissatisfaction about telephone access to the practice. Records showed that that telephone access was regularly reviewed and monitored at PPG meetings.

Patients told us that they felt involved in decisions about their care and treatment and that their questions were answered. This was consistent with national patient survey data which highlighted that 80% of respondents said their GP was good at involving them in decisions about their care (better than the average for Barnet practices).

In addition to the national GP patient survey 2014, the practice also participated in a targeted national survey of 927 practices of a similar size. We noted that the 294 patients who responded were most positive about explanations, warmth of greeting and respect shown by staff and most negative regarding waiting times, phone access and ability see a practitioner of their choice. Overall 75% of patient ratings about the practice were either good, very good or excellent.

Areas for improvement

Action the service SHOULD take to improve

- Use its monthly, non clinical staff team meetings to discuss significant events, complaints or share learning; to improve outcomes for patients.

Outstanding practice

- On visits to care homes, GPs used a secure Wi-Fi computer connection to enable their lap tops to access the practice's clinical software system. Clinical records (including electronic prescribing) could be updated from the care homes as opposed to back at the practice. This enabled responsive and patient centred care.

The Speedwell Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP specialist advisor and an expert by experience.

Background to The Speedwell Practice

The Speedwell Practice 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) 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.

The Speedwell Practice has a patient list of approximately10,800 (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 three senior GPs (2 female, 1 male), 4 salaried GPs (2 male, 2 female), 2 practice nurses, nurse practitioner, practice manager, healthcare assistant and administrative and reception 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.

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.

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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 09 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.

Good

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, practice nurses' outline of how they would report safeguarding concerns was consistent with the practice's safeguarding policy for children and vulnerable adults.

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. For example, the practice manager confirmed they were on the circulation list for receiving alerts and also outlined their role in ensuring that printed copies were on file.

There were effective arrangements in place to report safety incidents in line with national and statutory guidance. For example, following an incident involving a patient, the practice had reviewed notes of patients experiencing or at risk of experiencing domestic violence and developed an action plan to improve patient disclosure.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at 11 events recorded since January 2014. They included a record of the area of concern, level of risk, investigation involving all relevant staff and actions taken to minimise the chance of reoccurrence. Significant events were discussed at weekly clinical meetings and a more detailed analysis took place at meetings which were held every six months. A senior GP was the significant events lead and had responsibility for sharing learning amongst staff. Their role also included helping staff to understand and fulfil their responsibilities to raise concerns and report incidents or near misses.

Records we looked at showed how the practice used significant events to improve the service such as changes to referral processes following a delayed patient referral and changes to how the practice acted on patient test results following a delay in contacting a patient. However, we also noted that learning points from these events were not shared at the practice's monthly non clinical staff team meetings.

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 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, who shared the same building.

The practice had a chaperone policy and we noted that staff who undertook chaperone duties had received in house training. We also noted that all staff had undergone Disclosure and Barring Service (DBS) checks.

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, young mothers who were deemed at possible risk and patients living with dementia.

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 looked at daily medicines refrigerators temperature records and noted two days in January 2014 where dates had not been recorded. We brought this to the attention of the practice nurse who told

us that their recording systems would be reviewed to minimise reoccurrence. The practice did not hold controlled drugs on the premises. Medicines were within their expiry date.

We saw that the practice undertook medications reviews triggered by drugs safety alerts or NICE guidance. For example, we saw an ongoing audit regarding the prescribing of two medicines, which had been triggered by a drugs safety alert. The audit identified patients at risk and the practice was in the process of involving the respective patients in the change of their medication.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All 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. However, we noted that hand gel was not available in the patient waiting area.

The practice's nurse practitioner was the Infection Prevention and Control (IPC) lead and responsible for ensuring effective infection control throughout the practice. Records showed that they had recently attended infection control training as part of this role. 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 the practice's consultation room couches were clean and in a good state of repair. We also noted that the practice's sharps bins were now signed and dated in accordance with the audit's action plan.

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). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

We saw evidence of calibration of relevant equipment within the last 12 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 taken place within the last 12 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. At the time of our inspection, Disclosure and Barring Service (DBS) background checks had been undertaken for all but one member of non clinical staff (for whom checks were being processed). 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. For example, minutes of clinical meetings showed that the practice had protocols in place for sharing and actioning patients' blood test results if the respective GP was on annual leave.

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.

Good

Are services safe?

For example, the practice's latest infection control audit identified and took appropriate steps to minimise risk from sharps containers. 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 oxygen. Regular checks of this equipment were undertaken by an allocated nursing staff member. Clinical staff had received cardiopulmonary resuscitation (CPR) training within the last 12 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 that the practice's clinical software failed). 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 six 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

Patients had comprehensive assessments of their needs which included consideration of clinical needs, mental health, physical health and wellbeing. For example, practice nurses told us that patients experiencing poor mental health were routinely contacted and invited to attend annual health checks so as to assess their physical and mental health needs. Information we reviewed before our inspection showed that the practice performed better than the national average for the percentage of patients with physical and/or mental health conditions whose notes contained an offer of support and treatment within the preceding 15 months. Dementia diagnosis rates were also better than the national average.

The practice had systems in place to ensure that patients' care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.

Records showed that the practice regularly invited specialist clinicians to clinical meetings and a senior GP explained the protocol for ensuring that clinical best practice (for example identified in specialist medical journals) was disseminated to all clinicians at the practice.

GPs undertook part time undergraduate teaching, hospital consultancy and specialist cancer commissioning roles; and the nursing team 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) guidance.

Management, monitoring and improving outcomes for people

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

We noted that one completed clinical audit had taken place in the last 12 months; using a standard practice clinical audit template covering objective, summary of results, action plan and proposed re-audit date. We also saw another audit which appeared incomplete and it was unclear how the results would be interpreted and used to improve patient care and treatment. The practice told us that this audit was used to identify patients on patent expiring medicines who could be considered for transfer over to cheaper, generic equivalent medicines.

We noted that clinical audits were linked to new clinical guidelines or safety alerts. For example, we saw that an ongoing audit regarding the prescribing of two medicines had been triggered by a drugs safety alert. The audit identified patients at risk and the practice was in the process of involving the respective patients in the change of their medication. Overall however, although clinical meetings included discussion of clinical audits, we did not see evidence of a planned programme of clinical audit being systematically used to improve outcomes for patients.

Information about patient's care and treatment, and their outcomes, was routinely monitored and information used to improve care. This included for example regular reviews of palliative care (end of life) patients.

The practice performed better than the England practice average in a number Quality and Outcomes Framework (QOF) areas for the year ending April 2014 (QOF is a national performance measurement tool). For example, the practice performed better than the England average for the percentage of patients with physical and/or mental health conditions whose notes contained an offer of support and treatment within the preceding fifteen months. Practice performance was also better than the England practice average for the occurrence of regular (at least three monthly) multidisciplinary review meetings where all patients on the end of life care register were discussed. We noted that dementia diagnosis rates were also above the England average.

QOF performance also highlighted that unplanned hospital admission rates for patients with diabetes were below the average for practices in Barnet and England. Practice nurses told us that the practice placed an emphasis upon educating and empowering patients to manage their condition. Practice records also showed that a recent clinical meeting focussing on recall of diabetic patients had resulted in an action plan which included staff training needs and a proposed audit to review the patient recall

Good

Are services effective?

(for example, treatment is effective)

system. QOF performance across a range of clinical areas was discussed at weekly clinical meetings with action plans developed as appropriate to improve performance. The practice was not an outlier for any QOF clinical targets.

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 with for example two having additional diplomas in sexual and reproductive medicine. There was also a mixture of female and male GPs. 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.

The practice had systems in place to identify and meet staff learning needs. Records of team meetings showed that managers were proactive in identifying and monitoring staff training needs.

Staff were supported to maintain and further develop their professional skills and experience. The nurse practitioner told us that the practice had supported them in achieving a post graduate clinical degree.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had had 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 managers regularly audited staff training needs and that there were discussed at staff team meetings.

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. We noted that the local health visiting and district nursing teams were located in the same building. The practice nurse was a former member of the district nursing team and regular discussions took place although these were not minuted. Practice staff were also aware of the local CCG child protection lead.

Minutes of clinical meetings showed that clinicians (such as cancer specialists) were regularly invited to attend practice clinical meetings. Records also showed that the practice worked closely with a range of services including Cancer Care UK and a local mental health trust. We were told that working with other services helped to facilitate patient centred care. For example, reception staff members' attendance at Cancer Care UK cancer awareness training had raised their awareness of cancer prevention messages. We also saw evidence of meetings to discuss the care of patients with long term conditions and/or end of life care needs.

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. The system also allowed web based access for example from local care homes or patients' homes which saved time and avoided transcription errors. The practice also had internal protocols to ensure that patient test results were promptly acted upon if they arrived and the respective GP was on leave.

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. A senior GP gave an example of where a patient had lacked the mental capacity to make a decision and was able to evidence that 'best interests' decisions had been made and recorded in accordance with legislation. Some patients with a learning disability lived at a local care home. We spoke with the manager who was positive about practice GPs' attendance and contribution to 'best interests' decisions meetings.

Health Promotion & Prevention

The practice worked closely with the local CCG to share information about the needs of the practice population

Good

Are services effective?

(for example, treatment is effective)

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.

For example, a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. 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 the reception area contained patient information on conditions which were prevalent amongst the local community such as diabetes.

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 and twenty four months was above the average for Barnet practices and dementia diagnoses rates were better than the national average. Seasonal flu vaccination rates for “clinical risk groups” such as patients with a learning disability or diabetes were also better than the national average. However, we also noted that cervical screening rates within the last five years for patients experiencing poor mental health were worse than the averages for Barnet and England.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Before our inspection, we looked at the 2014 national GP patient survey results which showed that 84% of patients found receptionists helpful. During our inspection, we observed that reception staff treated patients with dignity and respect. Records showed that reception staff had received customer care training with the last 12 months and that managers were proactive in observing how reception staff engaged with patients, so as to identify training needs. Patients spoke positively about how they were treated by GPs and this was consistent with comment card feedback. We also noted that staff wore name badges.

The practice offered a chaperone service which was publicised in reception. Reception staff undertaking chaperone duties wore badges advising patients, had received training and had undergone DBS checks.

The 2014 GP patient survey results also showed that 89% of patients reported that other patients could overhear what they were saying to the receptionist (below the Barnet and England average). During the inspection, we observed that the reception area was adjacent to the waiting areas in the practice and that conversations between the receptionist and patient patients could be overheard. Staff told us that following PPG feedback, the practice had recently made changes to the reception area to improve privacy and that further works were planned. Records showed that these plans had been discussed at recent PPG meetings and a timetable of actions agreed.

Care planning and involvement in decisions about care and treatment

The 2014 GP patient survey reported that 80% of respondents said the last GP they saw or spoke to was good at involving them in decisions about their care (better than the Barnet practice average). During our inspection, patients told us that they felt involved in decisions about their care and treatment and this was also a consistent theme of comment card feedback. We also noted that the practice performed 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 learning disability care home manager also spoke positively about GPs' involvement where a patient lacked mental capacity to make a particular decision regarding their care such as "best interest" decisions. Staff were confident in their knowledge of consent and the importance of the ongoing assessment of capacity. For example, a senior GP stressed the importance of assessing patients' capacity to make decisions on the day as opposed to solely basing this upon patient notes.

Patient/carer support to cope emotionally with care and treatment

The practice routinely wrote to patients diagnosed with cancer to offer support and help ensure that patient care was coordinated between the practice and specialists as required. The practice also signposted patients to organisations providing specialist support. Records showed that end of life care nurses regularly attended multi-disciplinary meetings at the practice.

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, 71% of annual patient survey respondents described their GP's concern for them as a person as "very good" or "excellent. This was consistent with patient feedback from discussions on the day and comment cards which highlighted that staff responded compassionately when patients needed help and provided support when required such as during times of bereavement.

Notices in the patient waiting room, on the TV screen and patient website also advised people how to access local and national support groups and organisations. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked.

Good

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 openings extended hours were available Monday –Friday in addition to a telephone consultation service. 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.

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's QOF performance was also better than the national average across a number of patient group areas such as the percentage of diabetic patients who had had a foot examination and risk classification in the previous 15 months and the percentage of patients with mental health conditions whose notes contained an offer of support and treatment within the preceding 15 months.

There had been very little turnover of staff during the last five years which enabled good continuity of care. Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to four local care homes on a specific day each week by a named GP and to those patients who needed one.

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 and three members spoke positively about how the groups' views were taken on board. For example, following PPG feedback the practice had introduced on line appointments system to improve patient access. We also saw that the group had an action plan which identified other areas for improvement with time scales.

In April 2014, the practice audited its systems for supporting patients at risk of or experiencing domestic violence. This resulted in an action plan to improve referrals to domestic violence agencies and to increase publicity about these services in reception and on the practice website. Staff had received domestic violence awareness training. The practice also worked with the local CCG on cancer awareness outreach at events in the area.

GPs routinely brought their Wi Fi enabled laptops on visits to care homes and used a secure computer connection to access the practice's clinical system and patient notes (including electronic prescribing). This saved time and avoided transcription errors.

Tackling inequity and promoting equality

The practice had ramped access to allow patients with mobility scooters and wheelchairs to access the practice. One of the toilets was wheelchair accessible and also 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. A wheelchair was available in reception for less mobile patients. 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. During our inspection, we noted that the reception desk did not include a lowered section to enable ease of access for wheelchair users and children.

The practice had recognised the needs of different groups in the planning of its services. For example, the practice offered extended appointments and "easy read" pictorial leaflets for patients with learning disabilities. We were told that some patients with a learning disability lived at a local care home. The manager spoke positively about how patients were treated by reception staff and about how clinicians explained treatments.

Annual health checks were provided for patients who experienced poor mental health. 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 phone call to the patient was made by their GP as they were more familiar to the patient than other staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 8:00am to 6:30pm on Monday to Friday. We were told that following Patient Participation Group PPG feedback, the practice had recently introduced staggered lunch times for reception staff; enabling the reception and phone service to remain open throughout lunch.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments online. Telephone consultations were 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.

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.

Patients we spoke with expressed dissatisfaction with the practice phone system. Some patients who lived locally told us that they preferred to attend the practice in person rather than try to get through by phone and make an appointment. They confirmed that they could usually see a doctor on the same day but commented that seeing the doctor of their choice could take up to three weeks.

Survey feedback also showed dissatisfaction at accessing the practice by phone. For example, only 33% of respondents to the GP national survey fed back that it was easy to get through to this surgery by phone (less than the average for Barnet practices). The practice's own patient survey was also negative regarding phone access, with some patients feeding back that they had been on hold waiting to speak with a member of staff for up to 50 minutes. The practice told us that they were aware of these concerns and that online booking and repeat prescriptions had recently been introduced to relieve pressure on the phone system. However, it was too early to identify any positive impact of these changes.

Comments received from patients were positive regarding early morning appointments (8am Monday to Friday); particularly those with work commitments.

The practice also offered a weekly "drop in" baby clinic where patients could see specialist clinicians, receive immunisations and also meet with other mothers.

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 evidence of how complaints were used to improve the service (for example steps to increase the capacity of the practice phone system).

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 NHS England. 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 practice reviewed complaints annually to identify themes or trends. We looked at the latest report (2014/15) and saw that almost nine out of fifteen complaints related to "administration" and that following investigation, six complaints were "fully justified." However, minutes of administrative staff meetings did not show that these had been discussed to identify learning points and any service improvements that might be required.

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 care and treatment; to understand and meet their needs and involved them in decision about their care and treatment. We spoke with a range of staff including reception staff, practice nurses, nurse practitioner 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.

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 looked at nine of these policies and procedures and saw that most had been reviewed within the last twelve months. We did not see a record confirming that staff had read the policies but staff we spoke with demonstrated an understanding. For example, reception staff were aware of the practice's safeguarding lead and how to escalate a concern; and the practice nurse was aware of the procedure to follow in the event they sustained a sharps injury.

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 saw how the practice used reviews to monitor quality and identify where action should be taken. For example, a domestic violence review had resulted in improvements to how at risk patients were identified.

We noted that the practice's weekly clinical meetings included discussion about performance, quality and risk such as changes to QOF, review of use of locums and systems to minimise the risk of patient test results being received but not actioned.

Leadership, openness and transparency

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 action plans developed as appropriate. For example, the practice had developed an action plan to improve recall rates for diabetic patients which focussed upon identifying best practice locally and an increased role for health care assistants in care and treatment. The practice was also subject to external peer review as it was part of a subgroup of practices in the area.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice's latest annual patient survey reported that 33% of respondents rated telephone access as "poor." As a result of this and PPG feedback, the practice had introduced on line bookings and repeat prescriptions to free up phone system capacity.

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, following PPG feedback, the TV in reception was now played health promotion information and also advised patients with a hearing impairment (and others) that their appointment time had arrived.

The practice generally received staff feedback at monthly team meetings but we noted that the minutes of these

Are services well-led?

Good

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

meetings did not show staff members' views being sought or acted upon. However, they told us that they felt involved and engaged in decisions about delivering care and treatment.

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, one practice nurse had attained their nurse practitioner qualification and a post graduate degree at the practice. Records showed that guest speakers regularly attended the practices' weekly clinical meetings. We noted that GPs undertook part time undergraduate teaching, hospital consultancy and specialist cancer commissioning roles; and the nursing team spoke positively about how this helped ensure that care was based upon latest guidance and best practice.

The practice had completed reviews of significant events and other incidents and we saw that these were available electronically to all staff. However, we also noted that monthly, non clinical staff team meetings did not discuss significant events, complaints or share learning to improve outcomes for patients.

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 teaching, hospital consultancy and specialist cancer commissioning roles.