

Langstone Way Surgery

Quality Report

28 Langstone Way

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

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Langstone Way Surgery on the 27 July 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of infection control.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said there was continuity of care, with urgent appointments available the same day.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

Importantly the provider must:

- Ensure infection control leads are provided with infection control training and the practice maintains cleaning schedules. To ensure that infection control audits are carried out in accordance with national guidelines.

In addition the provider should:

- Provide equality and diversity and fire safety training to its staff team.

- Continue to raise patient's awareness of the availability of the Patient Participation Group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), and online booking facilities.

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?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed with the exception of risks related to infection control. Infection control leads had not received infection control training and cleaning schedules had not been maintained to ensure an audit trail. Infection control audits for the last three years had not been completed. There was enough staff to keep patients safe.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. The data from the GP Patient Survey 2014 told us patients had confidence in the clinical staff they saw. The majority of patients said they had confidence and trust in the last GP they saw or spoke to and said the same about the last nurse they saw. Patients were positive about their experience during consultations with the GPs with most stating the GP was good at listening to them. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness, respect and maintained confidentiality.

Notices in the patients' waiting room, told patients how to access a number of support groups and organisations.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was

Good



Summary of findings

available and easy to understand. The practice responded quickly to issues raised and learned from complaints. The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Patients were provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

Are services well-led?

The practice is rated as good for being well-led. All staff were aware what their responsibilities were in relation to providing a good quality service. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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

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

Good



People with long term conditions

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

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Immunisation rates were above the CCG average for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). There was a variety of appointment options available to patients such as telephone consultations, on-line booking and extended hours. The practice offered online prescription ordering with a 48 hour turn around and online appointment services.

The practice was performing well in undertaking cervical smear examinations and performance for cervical smear uptake was in line with the CCG average. Patients who did not attend for cervical smears were followed up by the practice nurses.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. It had carried out annual health checks for people with a learning disability and offered longer appointments.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, for example with the community mental health team. The practice was in the process of promoting regularised annual health checks to ensure people's physical health needs were also met. There was a system in place for a GP to review the patient's records if they did not attend for their appointment.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Good



Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014, which highlighted that patients were satisfied with the practice and that they were treated with compassion, dignity and respect. The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 107 patients who completed the survey, 92.6% said they had confidence and trust in the last GP they saw or spoke with and 98.3% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with GPs and 79.6% practice respondents said their GP was good at listening to them, describing their experience as very good. Other areas where the practice compared well

with the Barnet Clinical Commissioning Group (CCG) average included: The last nurse patients saw or spoke to was good at giving them enough time was 93.3% compared with the CCG average of 87.6%, the last nurse patients saw was good at explaining tests and treatments was 88.8% compared with the CCG average of 88.8%.

We asked patients to complete CQC comment cards to tell us what they thought about the practice and did not receive any completed CQC comment cards. We spoke with 12 patients, who made positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

Areas for improvement

Action the service **MUST** take to improve

- Ensure infection control leads are provided with infection control training and the practice maintains cleaning schedules. To ensure that infection control audits are carried out in accordance with national guidelines.

Action the service **SHOULD** take to improve

- Provide equality and diversity and fire training to its staff team.
- Continue to raise patient's awareness of the availability of the Patient Participation Group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), and online booking facilities.

Langstone Way Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and included a GP, a practice manager and an expert by experience who were granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Langstone Way Surgery

Langstone Way Surgery is situated within NHS Barnet Clinical Commissioning Group. The practice holds a Personal Medical Services contract (Primary Medical Services agreements are locally agreed contracts between NHS England and a GP practice) and provides a full range of enhanced services including adult and child immunisations, learning disabilities services, and remote care monitoring.

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

The practice had a patient list of 6400 at the time of our inspection.

The staff team at the practice included two male GP partners and four salaried female GPs, three female practice nurses, two female healthcare assistants and a practice manager and a team of administrative staff (all working a mix of full time and part time hours). Langstone Way Surgery was not an approved training practice for GP Registrars.

The practice was open between 08:00 and 18.30 Monday to Friday, except Thursday as they closed at 13.30.

Appointments were available all day and the practice did not close during the day. Extended hours surgeries were available on a Tuesday from 18.30 to 20.00.

To assist patients in accessing the service there was an online booking system, text message reminders for appointments and test results. Urgent appointments were available each day and GPs also completed telephone consultations for patients. The out of hours services were provided by a local deputising service to cover the practice when it was closed.

Langstone Way Surgery serves a less deprived population and its deprivation score is significantly lower than the England average. The population in Barnet overall is younger than the England average, yet there is a comparatively high prevalence of long term conditions such as diabetes, hypertension and severe enduring mental illness. Life expectancy in Barnet is 79 years for males which is in line with the England average and 85 years for females which is above the England average of 83 years.

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

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

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

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

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

- Older people

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 July 2015. During our visit we spoke with a range of staff such as the GPs, practice manager and administrative staff. We spoke with ten patients. We reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, they reported incidents and used national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used a central log to record significant events which the practice manager managed. Fourteen significant events had been recorded for the last 12 months. We tracked two incidents and saw records were completed in a comprehensive and timely manner. They were discussed routinely at clinical and non-clinical meetings to discuss the effects on patients and staff, to share learning and to identify actions to prevent recurrence. For example, the wrong dose of medication was prescribed to a patient was documented and learning was shared with all clinical staff. A letter of apology was also sent to the patient.

Another event we tracked included a patient with poor mental health. The patient was placed into the waiting room but left without informing staff. The event was discussed with all staff at a practice meeting and a change to practice policy was made to ensure vulnerable patients were seated where reception staff could see them. Plans were also discussed to lower the reception desk to improve patient accessibility. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email and discussed in clinical meetings and then placed onto the intranet. We saw Medicines and Healthcare Products Regulatory Agency (MHRA) alerts to ensure best practice.

We saw alerts the practice had received and evidence of them being discussed in clinical and practice meetings. Minutes from clinical meetings showed, for example, an alert on the change of dose an anti-psychotic drug being discussed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all non-clinical staff had received relevant role specific training on safeguarding in both adults and children. We were provided with written documents to evidence that all clinical staff including nursing staff had received Level 3 child protection training and training in safeguarding adults.

We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a GP and a practice nurse as the leads in safeguarding vulnerable adults and children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans. The practice kept a child protection and adult safeguarding register.

Records demonstrated good liaison with partner agencies such as the police, social services and health visitors. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed

Are services safe?

appointments frequently. These were brought to the attention of GPs, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. All members of the reception team had received chaperone training but only two members of the non-clinical team acted as a chaperone if nursing staff were not available. Non-clinical staff who were on the practice chaperone list had received Disclosure and Barring Service (DBS) checks, (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the three medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records we saw showed room temperature and daily fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. We looked at a sample of vaccinations and found them to be in date.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Prescriptions were kept in a locked room and prescription serial numbers were logged.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used up to date Patient Group Directions (PGDs) that had been produced in line with legal requirements and national guidance to administer vaccines and other medicines.

Cleanliness and infection control

We observed the premises to be clean and tidy. Clinical waste was handled, stored and disposed of appropriately. We were not provided with written cleaning logs to evidence that cleaning was taking place on a daily basis. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. A policy for needle stick injury was in place and staff knew the procedure to follow in the event of an injury.

All staff received induction training about infection control specific to their role. The practice had a lead for infection control who was one of the practice nurses, but they had not undertaken further training to enable them to provide advice on the practice infection control policy or carry out staff training. An infection control risk assessment had been completed in 2015. However, infection control audits had not been completed for the last three years.

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment for legionella in June 2015 and had decided that the risk was sufficiently low to make formal testing unnecessary.

Are services safe?

Equipment

Staff we spoke with told us they had the equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer all calibrated annually.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the recruitment files for two recently recruited practice nurses which contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Locum cover was used for the GPs and practice nurses to cover sickness and annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The management showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice manager was responsible for the compliance with fire, legionella and other health and

safety regulations for the premises. There were procedures in place for monitoring and managing risks to patient safety. All new employees working in the building were given induction information for the building which covered health and safety and fire safety. There was a health and safety policy available for all staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan was last reviewed in 2015.

There was a fire risk assessment in place that was reviewed by the practice manager. Fire drills were completed every six months and fire alarms were tested weekly. However, staff had not received training in fire safety.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register.

Once patients were registered with the practice, the practice nurses carried out a full health check which included information about the patient's individual lifestyle as well as their medical conditions. Patients were booked for a longer appointment to discuss their needs and to also be introduced to what services were available in order for patients to make best use of the practice. The practice nurses referred patients to the GP when necessary.

The practice took part in the avoiding unplanned admissions scheme. The clinicians reviewed their

individual patients and discussed patient needs at weekly clinical meetings to ensure care plans were in place and regularly reviewed. Any information from the meetings were disseminated to other staff as required.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

All GPs and nursing staff were involved in clinical audits. The practice showed us three completed clinical audits. Examples included audits in hypertension, osteoporosis and cancer diagnosis. Changes to treatment or care were made where needed as a result of the audits. The osteoporosis audit's aim was to consider patients for a drug holiday that had been on Bisphosphonates for five years or more. During the first cycle in August 2014, 57 patients were found to be on the medication and in March 2015 when the

cycle was completed the number of patients on the drug had reduced to 49. Conclusions from the audit were for the practice to complete periodic searches for patients on the medication and to monitor repeat medications more robustly. The audit on cancer diagnoses examined the percentage of patients diagnosed with cancer in the last six months who were referred under the two week wait rule (which gives patients the right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected). The findings concluded that referrals were timely and appropriate and did not demonstrate any change in practice.

The practice also met with the local (CCG) quarterly to discuss and compare their performance with other practice within the CCG. For example, the practice compared its anti-biotic prescribing data and their practice achievement to CCG data.

The practice participated in the Quality and Outcomes Framework system (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example the practice met all the standards for QOF in dementia, palliative care and arterial fibrillation. It achieved most of the standards for diabetes (achieving 88.7%), asthma (achieving 90.1%) and cancer (achieving 99.3%).

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicine alerts when the GPs were prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs reviewed the use of the medicine in question. The evidence we saw confirmed that the GPs had oversight and a good understanding of the best treatment for each patient's needs.

Effective staffing

Practice staff included two GP partners and four salaried GPs, three practice nurses, a health care assistant, a practice manager and a team of administrative staff. The practice had an induction programme for newly appointed

Are services effective?

(for example, treatment is effective)

members of staff that covered such topics as fire safety, health and safety and confidentiality. We reviewed staff training records and saw that all staff were up to date with attending mandatory training courses such as annual basic life support, safeguarding adults and chaperoning. The practice nurses attended local practice nurse forums and attended a variety of external training events. The nurses were supported to attend meetings and events.

All GPs were up to date with their yearly continuing professional development requirements and they had been or were in the process of being revalidated. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). All staff undertook annual appraisals that identified learning needs from which action plans were documented. We reviewed five staff files, which confirmed this.

Working with colleagues and other services

The practice received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GPs who saw these documents and results, were responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice worked with other service providers to meet patient needs and manage complex cases. It held bi-monthly clinical multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. There was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals; the practice used the Choose and Book system, which enabled patients to choose which hospital they would like to be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to the Accident & Emergency (A&E) department. The practice was using the electronic patient record system, and highlighted the importance of this communication with A&E

The practice had systems to provide staff with the information they needed. Staff used electronic patient records to coordinate, document and manage patients' care. 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.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this legislation. These processes highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

All clinical staff demonstrated a clear understanding of Gillick competencies. These helped clinicians to identify children aged under 16 who had the legal capacity to consent to medical examinations and treatment.

Health promotion and prevention

The practice had a variety of patient information available to help patients manage and improve their health. There were health promotion and prevention advice leaflets available in the waiting rooms for the practice including information on dementia.

The practice signposted patients to additional services such as lifestyle management and smoking cessation clinics.

Are services effective?

(for example, treatment is effective)

We noted a culture among the GPs to use their contact with patients to help maintain physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and had 10 patients on the register who were all offered an annual physical health check.

Of the patients who required a smear test in the last five years, 80.95% of patients had received one, compared to the CCG average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice nurses were responsible for following up these patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was above the CCG average, for example 86.6% of children aged 24 months had received an MMR vaccination compared to the CCG average of 80.3%; 91.4% of 5 year old children had received the PCV Booster compared to the CCG average of 85%.

The practice had reviewed 89.47 % of its patients diagnosed with dementia in a face to face review in the preceding 12 months, compared to the national average of 83.82%.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP Patient Survey 2014, which highlighted that patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the GP Patient Survey told us patients had confidence in the clinical staff they saw. For example, out of 107 patients who completed the survey, 92.6% said they had confidence and trust in the last GP they saw or spoke with and 98.3% of patients said the same about the last nurse they saw. Patients were positive about their experience during consultations with GPs and 79.6% practice respondents said their GP was good at listening to them, describing their experience as very good. Other areas where the practice compared well with the Barnet CCG average included, the last nurse patients saw or spoke to was good at giving them enough time was 93.3% compared with the Barnet average of 87.6%, and the last nurse patients saw was good at explaining tests and treatments was 88.8% compared with the Barnet average of 88.8%.

We asked patients to complete CQC comment cards to tell us what they thought about the practice in the two weeks prior to the inspection but did not receive any completed CQC comment cards. We spoke with 12 patients, who made positive comments about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

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

Staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. However, conversations between reception staff and patients could be heard at the reception desk and it was difficult for the

practice to promote privacy in this environment. The practice manager told us that if a patient wished to speak privately they would accommodate this and they agreed to put a notice up reminding patients of this facility.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would conduct an investigation and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The GP Patient Survey 2014 and comment cards we received showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, data from the GP Patient Survey showed 80% of respondents said the GP involved them in care decisions compared to the CCG average of 79.9% and 80.4% of patients felt the GP was good at explaining treatments compared to the CCG average of 88%. The survey also showed that approximately 95% said the last nurse they saw or spoke to was good at treating them with care and concern which was above the CCG average of 86%.

The service had access to a translation service to support those patients where English was not their first language. Staff we spoke with told us they did not need to use this service often but knew how if needed.

Patient/carer support to cope emotionally with care and treatment

The practice website offered patients information as to what to do in time of bereavement and also referred them to a local counselling service.

Notices in the patient waiting room, advised patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer and the practice assessed carers' needs and kept a register of these individuals.

Are services caring?

We saw that older patients identified as at risk of isolation were discussed at clinical meetings as well as to address the support they required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. We were informed that there was close liaison between the practice and the CCG and there was documented evidence to confirm that discussions with the CCG had led the practice to implement service improvements or manage delivery challenges to its population. For example, the practice had signed up to a number of directed enhanced services, which included services for patients with dementia to promote early diagnosis and intervention.

Although, the practice had actively promoted its Patient Participation Group (PPG), (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care), they had limited success with patients responding and was exploring other ways of activating the group. We were informed the practice struggled with getting patients to attend PPG meetings. Instructions on how to join the PPG were displayed around the practice as well as on the practice website. A PPG chair had been recently appointed who we spoke with. They informed us the practice was promoting the group and was trying to encourage more patients to join and they were exploring the idea of a virtual PPG to help aid patient involvement.

The 12 patients we spoke with said they were very happy with the efforts the practice had taken to involve them in their care. They felt that their concerns were listened to and suggestions were always implemented and they had seen some marked improvements at the practice in the past. For example, improvements in the telephone call back service by the GP.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients who needed the telephone translator service. The website provided comprehensive information about the practice and the

services it offered. It provided information about a wide range of health problems and diseases, and about health topics including childhood vaccines, stopping smoking, contraception and mental health.

The premises and services had been adapted to meet the needs of people with disabilities. For example, there was pram and wheelchair access on the ground and first floor. There was a lift in place. An area at the side of the reception desk was low than the rest of the desk to make wheelchair accessible

There were male and female GPs in the practice and staff told us they could usually accommodate patients' GP gender preferences.

An alert system on the computer records was used to flag patients with additional needs, for example patients made vulnerable by social isolation or a learning disability.

The practice had not provided equality and diversity training to its staff team. Although, this training had not been provided, equality and diversity was regularly discussed at staff appraisals, practice team meetings and a policy was in place.

Access to the service

The practice was open between 08:00 and 18.30 Monday to Friday, except Thursday as they closed at 13.30. Appointments were available all day and the practice did not close during the day. Extended hours surgeries were available on a Tuesday from 18.30 to 20.00.

To assist patients in accessing the service there was an online booking system, text message reminders for appointments and test results. Urgent appointments were available each day and GPs also completed telephone consultations for patients. The out of hours services were provided by a local deputising service to cover the practice when it was closed.

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 through the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on

Are services responsive to people's needs?

(for example, to feedback?)

their circumstances. Information on the out-of-hours service was provided to patients on the practice website as well as through posters and leaflets available at the practice.

Longer appointments were available with a named GP, nurse or healthcare assistant for people who needed them, for example those with long-term conditions. Home visits were made to those patients who needed one, such as older patients and those with long term conditions.

The GP Patient Survey 2014 highlighted low numbers of patients satisfied with the appointments system with 56.9% of patients who described their experience of making an appointment as good and only 58.9% informing that they found it easy to get through to the surgery by phone. The practice in response to the survey informed us they had implemented an action plan and were planning to increase the number of GP sessions by recruiting another permanent GP. They informed that they had previously provided a half time GP to provide additional appointments to ease winter pressures but the funding had ceased in April 2015.

Out of the 12 patients we spoke with several patients were not aware of the option of booking appointments online. This was discussed with the practice management who informed us they would be looking at how they could promote this service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in

line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. Patients were also provided with the contact details of The Independent Complaints Advocacy Services (ICAS) and the Patient Advice and Liaison Services (PALS) to support them with their complaints.

We saw that information was available to help patients understand the complaints system such as posters displayed in the reception area.

The practice had recorded 13 complaints in the last 12 months. They were satisfactorily handled and were dealt with in a timely way which was in accordance with the practice's complaints policy. Each complainant was written to, discussing their complaint in detail.

All complaints including verbal complaints were thoroughly recorded and we saw evidence of openness and transparency when dealing with complaints. Verbal complaints were recorded in writing to ensure they were not missed and were also responded to in writing.

The practice reviewed complaints on an on-going basis by discussing complaints at its practice and clinical meetings to detect themes and trends and to ensure lessons were learned from individual complaints. We saw from the minutes that complaints were routinely discussed to ensure all staff were able to learn and contribute to determining any improvement action 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

A formal written vision had been documented and all staff we spoke with all knew and understood what their responsibilities were in relation to providing a good quality service, being patient centred, listening and being responsive. Comments we received from patients we spoke with were very complimentary of the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We reviewed a number of policies, for example the induction policy and recruitment policy, which were in place to support staff. They were detailed and provided appropriate guidance for staff. We were shown the policies for staff on equality, harassment, whistleblowing and bullying at work. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control, safeguarding, medication management audits, health and safety, fire safety, information governance and patient complaints. We spoke with four members of staff who told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff were encouraged to learn and develop their careers.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify

where action should be taken. Examples included audits in hypertension, osteoporosis and cancer diagnosis. Changes to treatment or care were made where needed as a result of the audits.

The practice had robust arrangements for identifying, recording and managing risks. The management showed us the risk log, which addressed a wide range of potential issues, such as risks to the building, staff, dealing with emergencies and equipment. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at clinical and non-clinical meetings.

The practice also had a health and safety policy. Health and safety information was on the practice intranet for staff to see.

The practice held monthly practice meetings which discussed governance. We looked at minutes from the last six meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The GPs were visible in the practice and staff told us that they were approachable and always took the time to listen. Staff were involved in discussions about how to run the practice and how to develop the practice and the provider encouraged staff to identify opportunities to improve the service delivered by the practice.

The practice aimed for monthly practice meetings. In addition there were weekly clinical meetings and non-clinical staff met on an ad hoc, more informal basis when needed, for example over lunch. Regular email communication between the practice manager and the administrative and reception staff showed governance issues were raised, discussed and resolved regularly.

Staff demonstrated there was an open culture within the practice and that they felt confident to raise any issues and felt supported when they did.

Seeking and acting on feedback from patients, public and staff

The practice valued feedback from patients and was seeking ways of getting more feedback from a wider range of its patients, especially younger people as they had limited success with engaging patients with the Patient Participation Group (PPG). There was a clear invitation to

Are services well-led?

Good 

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

join the PPG on the practice website, or to submit comments, suggestions and complaints. The practice offered patients the opportunity to take part in the NHS friends and family test.

The twelve patients we spoke with said they were very happy with the efforts the practice had taken to involve patients in their care. They felt that their concerns were listened to and suggestions were always implemented and they had seen some marked improvements at the practice. For example, they told us they had seen improvements in the telephone call back service by GPs.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Regular appraisals took place which included a personal development plan for staff. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings. There were records of significant events that had occurred during the last year and we were able to review these. There was evidence that the practice learned from these and that the findings were shared with relevant staff.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The registered person had not ensured that infection control audits had been completed for the last three years in line with national guidance. The infection control lead had not received additional training in infection control. Cleaning schedules for the cleaning of the practice had not been maintained to ensure an audit trail and evidence that daily cleaning had taken place. 12 (2) (h).</p>