Brondesbury Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 carried out an announced comprehensive inspection at Brondesbury Medical Centre on 21 October 2014. This is the only location operated by the provider. Overall the practice is rated 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, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. Our key findings were as follows:

- There were arrangements in place to ensure patients were kept safe.
- Patient's needs were assessed and care was delivered in line with current best practice guidelines.
- Patients said they were treated with compassion and kindness and that they were involved in care and treatment decisions.
- Information about services and how to complain were available and easy to understand.
- The practice had a clear leadership structure and staff felt supported in their roles by the management team.
- The practice gathered feedback from patients and acted on it to improve services.

We saw some areas of outstanding practice including:

- Participation in pilot schemes including the 'Patient Partner' system that enabled patients to book, cancel and check appointments using their telephone keypad 24 hours a day.
- Employing a practice care co-ordinator to support the needs and optimise management of the patient population.

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

The provider must:

- Review the protocols and documentation of temperature monitoring for all clinical fridges to ensure that national guidance is followed.

Summary of findings

- Ensure that all staff called upon to act in the role as a chaperone have undertaken a Disclosure and Barring Service (DBS) check, and have undergone appropriate training.

The provider should:

- Implement regular fire drills.
- Implement formal health care associated infection control training for all staff.
- Review the specimen drop-off point in the reception area to ensure that patient confidentiality is always maintained.
- Review the positioning of sharps bins in all consultation rooms to ensure that they are all safely located.

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 good for providing safe services. Staff understood their responsibilities to raise concerns and there was a system in place to report and learn from significant incidents and near misses. Staff were trained in safeguarding and understood their roles in protecting vulnerable patients from potential harm. There were enough staff to keep patients safe. There were procedures in place and appropriate equipment available to manage medical emergencies. There were protocols in place for the safe management of medicines, however, the fridge temperature check protocol was not fully being followed and is an area for improvement.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health Care and Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current best practice guidelines. Data showed patient outcomes were at or above average for the local area. Staff had received training appropriate to their roles and further training needs were identified and planned through annual appraisals. Staff worked regularly with multi-disciplinary teams. The practice had services in place to promote good health in their patient population. The practice participated in the national research program CANDID (Clinical prediction rules for colorectal and lung cancer) co-ordinated by the University of Southampton. They also participated in pilot schemes including the 'Patient Partner' system that enabled patients to book, cancel and check appointments using their telephone keypad 24 hours a day.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with kindness, compassion and respect. They felt involved and supported in decisions about their care and treatment. We saw that staff treated patients with compassion and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning

Summary of findings

Group to secure improvements to services, where these were identified. Risk assessment tools were used to identify patients with complex needs and to plan their care accordingly. The practice made improvements to their service as a result of patient feedback. Patients were satisfied with the practice opening hours and access to appointments. There was a complaints policy and evidence the practice learned from complaints and made improvements to services.

Are services well-led?

Good

The practice was rated as good for being well-led. It had a clear vision and strategy. Staff were aware of the practice vision and understood their responsibilities in relation to it. The practice had a number of policies and procedures to govern activity. There was a clear leadership structure and staff felt supported by the management team. The practice sought feedback from patients through surveys and an active patient participation group. There was evidence the practice acted on feedback from patients to improve the service. Staff feedback was encouraged through team meetings and appraisals. The practice was a training practice and GP trainees spoke highly of the training and support they received.

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. There was a named GP for all patients over 75 years of age to co-ordinate care. The practice employed a care co-ordinator to support the needs of patients requiring regular review and their role included arranging medication reviews and identifying patients who needed additional input, such as flu vaccination, when they attended the practice for an appointment. The practice was accessible for patients with mobility difficulties. There were home visits available for patients unable to attend the practice due to illness or immobility. The practice reviewed and updated the care plans of patients who had been admitted to hospital as an emergency. The practice offered a flu vaccination service in line with national guidance.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. There were clinical leads in specialist areas including diabetes, asthma and chronic obstructive pulmonary disease (COPD). Patients with long term conditions had a named GP and were able to make pre-bookable appointments to see their doctor. Patients with long term conditions were invited to annual reviews and health checks and the practice employed a care co-ordinator who had a role in arranging these annual checks and medication reviews. The care co-ordinator also identified patients who needed additional input such as medication review or flu vaccinations opportunistically when they attended the practice for appointments. There were regular multidisciplinary meetings with a variety of health professionals to discuss and manage the care plans of patients with complex needs. The practice reviewed and updated the care plans of patients who had been admitted to hospital as an emergency. The practice offered a flu vaccination service in line with national guidance. GPs could refer patients to the expert patient program which was a self-management course to help patients take control of their health.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young children. There was a weekly 'one stop shop' baby clinic with the GP and Health Visitor that provided post natal review and baby checks. The practice offered a childhood vaccination programme in line with national guidance and uptake rates for these were above the CCG average for the local area. Practice nurses had received

Summary of findings

training in family planning and one of the GPs ran an intra-uterine contraceptive device clinic (IUCD). The practice nurses offered cervical smears as part of the national screening programme and the uptake rate was comparable to other practices in the area.

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 practice offered extended opening hours to ensure people who worked had access to appointments. There was the facility to book appointments online as well as by telephone. The practice offered health checks to new patients and reported good uptake rates. The practice participated in a pilot 'Patient Partner' scheme that enabled patients to book, cancel and check appointments using their telephone keypad 24 hours a day.

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances make them vulnerable. The practice kept a register of patients with learning difficulties and offered annual health checks and medication reviews to these patients. Invites to these health checks were in the format of an easy to read pictorial letter that encouraged patients to bring their carers to the appointment. The practice kept a register of patients who were carers and this was flagged up on their electronic records to alert staff when they attended for an appointment. The practice had access to an in house substance misuse and alcohol abuse service for vulnerable patients requiring this support.

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). Staff were aware of the Mental Capacity Act 2005 and understood their responsibilities to make capacity assessments and support patients to be involved in decisions about their care. The practice kept a register of patients experiencing poor mental health and they were invited to annual assessments including medication reviews, blood tests to monitor medication levels and physical health checks. Ninety percent of patients experiencing poor mental health had written care plans agreed. The practice had access to in-house Improving Access to Psychological Therapies (IPAT) services. The practice received regular support and advice on complex patients from the Camden Community Mental Health Team (CMHT) for those patients who resided in the London Borough of Camden.

Summary of findings

What people who use the service say

During our inspection we received 45 Care Quality Commission (CQC) comment cards that patients had completed and spoke with 12 patients including two members of the practice's patient participation group (PPG). We reviewed data from the National GP Survey published by NHS England July 2014. Overall the feedback from each source was positive.

Completed CQC comment cards were mostly positive with patients stating that they were satisfied overall with the standard and service provided. Patients considered that staff were generally polite, helpful and professional. Eight patients reported that they had experienced problems with waiting times in the waiting area and three patients were dissatisfied with how slowly telephones were answered.

Patients we spoke with generally felt that staff were kind and compassionate and that they were confident with the care and treatment provided by the GP's and nursing staff. They considered that doctors had enough time to listen fully and that they were good at providing emotional support alongside medical care. Some patients expressed that they had sometimes experienced problems getting through on the phone.

There was a 19% completion rate for the national GP patient survey (86 returned of 454 surveys sent out). Eighty-nine per cent of respondents found the receptionists at the practice helpful, 75% thought the nurse they last saw was good at listening to them and 83% felt the last GP they saw was good at explaining tests and treatments. Eighty-one per cent of respondents felt their last appointment was convenient to them and 26% reported difficulties getting through to someone at the GP surgery by telephone.

Areas for improvement

Action the service MUST take to improve

- Review the protocols and documentation of temperature monitoring for all clinical fridges to ensure that national guidance is followed.
- Ensure that all staff called upon to act in the role as a chaperone have undertaken a Disclosure and Barring Service (DBS) check, and have undergone appropriate training.

Action the service SHOULD take to improve

- Implement regular fire drills.
- Implement formal health care associated infection control training for all staff.
- Review the specimen drop-off point in the reception area to ensure that patient confidentiality is always maintained.
- Review the positioning of sharps bins in all consultation rooms to ensure that they are all safely located.

Outstanding practice

- Participation in pilot schemes including the 'Patient Partner' system that enabled patients to book, cancel and check appointments using their telephone keypad 24 hours a day.
- Employing a practice care co-ordinator to support the needs and optimise management of the patient population.

Brondesbury Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, practice manager and an expert by experience. They were granted the same authority to enter the registered person's premises as the CQC inspectors.

Background to Brondesbury Medical Centre

Brondesbury Medical Centre is a well-established GP practice situated on Kilburn High Road which is on the border between the London Boroughs of Camden and Brent. The practice provides primary medical care services to approximately 16,900 registered patients out of whom an estimated 8,000 patients live in the London Borough of Brent and the remainder in the London Borough of Camden. Cross-border issues are a challenge for the practice, for example in dealing with and making referrals to two London Borough community support services.

The practice has a predominately young patient demographic with the largest age distribution between 20 - 39 years of age. There is a higher deprivation score for the practice population compared to local and national Clinical Commissioning Group (CCG) averages. There is a high rate of mental illness and substance and alcohol misuse within the practice population.

The practice team includes one female and three male GP partners, two male and seven female salaried GPs, two female practice nurses, one female nurse practitioner, three female health care assistants (HCA) and a team of 18 administration and reception staff led by a practice manager. The practice is a training practice and currently hosts five GP registrars and one foundation year two (FY2) doctor.

The practice holds a Primary Medical Services (PMS) contract with NHS Camden Clinical Commissioning Group (CCG). The services provided include checks for diabetes, chronic obstructive pulmonary disease (COPD), asthma review, minor surgery, and child health care. The practice also provides health promotion services including a flu vaccination programme, smoking cessation clinics and cervical screening. The opening hours are 07.30am to 6.30pm on Mondays, 08.00am to 8.00pm Tuesdays and Thursdays and 08.00am to 6.30pm Wednesdays and Fridays. The practice is closed for lunch between 1.00pm to 2.00pm Mondays to Fridays. The out of hours services are delivered by an alternative provider.

The Care Quality Commission (CQC) intelligent monitoring placed the practice in Band 4. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a wide range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National GP Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

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.

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.

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.

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 met with NHS England, NHS Camden Clinical Commissioning Group (CCG), Healthwatch Brent and Healthwatch Camden and reviewed the information they provided us with. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 21 October 2014.

During our visit we spoke with a range of staff including GPs, practice managers, practice nurses, the care co-ordinator, reception and administration staff. We also spoke with 12 patients who used the service including two members of the patient participation group (PPG) established at the practice. We looked around the building, checked storage of records, operational practices and emergency arrangements. We reviewed policies and procedures, practice maintenance records, infection control audits, clinical audits, significant events records, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed Care Quality Commission (CQC) comment cards completed by patients who attended the practice in the days before and during our visit.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, safety incidents, national patient safety alerts as well as comments and complaints from patients who used the service. Safety incidents were discussed as a standing agenda item at fortnightly practice meetings. Staff we spoke with were aware of their responsibilities to raise concerns and could describe the processes to follow when reporting incidents or near misses. For example, following an event in July 2014 when a burst water pipe in the local area caused flooding of the ground floor of the building preventing access, the practice had revised their disaster recovery plan. This included actions to inform patients by text message about any issues with the premises and to ensure that copies of the recovery plan were kept off site by key staff.

An incident and accident book was kept in the reception which was used to record incidents that had occurred for the last five years. We reviewed the associated significant incident analysis reports from the last six months which demonstrated that the practice had managed safety incidents consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Records were kept of significant events that had occurred over the last five years. We saw minutes from fortnightly practice meetings in June and October 2014 that confirmed significant incidents were a standing agenda item. A dedicated significant events meeting occurred approximately every two months to discuss and share learning from recent events with all staff. Staff we spoke with including administration staff were aware of the system for reporting incidents and felt supported to discuss urgent concerns directly with the practice manager if required.

This was reviewed by the practice manager and GP partners in the fortnightly practice meeting and an action plan and learning points were recorded for each event. Outcomes and learning from each incident were then shared with the relevant staff. We reviewed a selection of significant events that had occurred in the last six months and saw evidence that action was taken as a result of these events to improve safety. For example, an incident when a practice nurse did not identify a clinical issue with a patient's blood test result led to the development of a process for the nurses to 'buddy up' with a GP colleague to discuss test results and ensure any abnormalities were followed up promptly.

The practice managers received safety alerts from a variety of organisations including the Clinical Commissioning Group (CCG), NHS England, Health Protection Agency, National Patient Safety Alerts (NPSA) and the Medicines and Healthcare products Regulatory Agency (MHRA). These alerts were cascaded to the GP partners who would action and disseminate them to practice colleagues.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice had a GP lead in child protection and safeguarding and staff were aware of their role and who to speak to if they had a safeguarding concern. The GP lead attended regular local safeguarding board meetings. Practice training records made available to us showed that clinical staff had received child protection training Level three and non-clinical staff at Level one. All staff had received training in safeguarding vulnerable adults including domestic abuse. There was an alert system to highlight vulnerable patients on the practice electronic records that appeared when those patients attended appointments. For example, if children were subject to any child protection plans.

A chaperone policy was in place and this was referred to in the staff handbook. Posters displayed the chaperone policy in the waiting rooms on the ground and first floor. Only one member of the reception had received chaperone training and this had not been recently updated.

The practice had a whistle blowing policy for staff to follow if they had any issues or concerns to raise. This was also documented in the staff handbook. Staff we spoke with were aware of their responsibilities to report any concerns.

Medicines management

The practice had three clinical fridges where medicines, vaccinations and other types of injections were stored. All three fridges had an integrated electronic thermometer and two had an additional probe thermometer, one of

which had been recently installed. A protocol and recording system was in place to check that medicine and vaccines were stored at the required temperature and included the actions to be taken in the event of a potential failure.

However, we observed that the protocol had not been followed on two occasions the week prior to our inspection, when temperature readings had fallen outside the recommended range. We found that no explanation for any known fluctuations in temperature readings had been logged and there was no record of any action taken. We brought this to the immediate attention of one of the GP partners who said that this would be investigated.

Following our inspection the practice wrote to advise us that as a result of their investigation it had been determined that the cold chain storage had been maintained. We were told that the fridge was empty and had been defrosted when the temperature reading had fallen out of the recommended range. We were advised that the current protocol and operational practices were being reviewed.

There was evidence that a stock rotation system was in place where older stock of vaccines and medicines were placed near the front of the fridge. However, we found that the fridge located in the consultation room on the first floor was heavily stocked and that some stock was stored against the back and sidewalls of the fridge contrary to recommended guidelines. Vaccines were administered by nursing staff using up to date directions that had been produced in line with legal requirements and national guidance.

Patients could request repeat prescriptions in person and online if registered to do so. Processes were in place for the review of repeat prescribing which included a medicine review reminder at least annually but sooner if there was a change in medicine prescribed or medical need. The practice care co-ordinator identified patients due for a medicines review and contacted them to arrange an appointment or raise an alert if a medical consultation had been scheduled with one of the GPs. Blank prescription forms were tracked through the practice and kept securely at all times.

There was a GP lead in medicine prescribing and the practice participated in the Camden Clinical Commissioning Group (CCG) prescribing quality scheme (PQS).

Cleanliness and infection control

The premises were clean and tidy. We reviewed the current cleaning schedule which was provided by an external contractor. All toilets had charts displaying the cleaning times and dates. One of the senior receptionists acted as the lead for the contract and would highlight any issues or concerns with cleaning to the practice management team. Curtains in all clinical rooms were disposable except for one but staff told us this was in the process of being changed.

One of the GP partners was the lead for infection control. The practice had an infection control policy available on the shared drive, however there was no formal infection control training provided for staff. We observed hand washing posters were displayed across the practice. A recent Clinical Commissioning Group (CCG) led infection control audit had been performed and required minor actions, for example sharp bins required labelling. The results of the audit were discussed at the practice meeting and we were told by staff all points raised had been addressed. We did observe in one of the consultation rooms that a sharps collection bin was not safely positioned as it was stored on a desk under a shelf. The practice had a needle stick injury policy and we were told there had been no needle stick injuries in the last year.

A Legionella policy was in place and a water system risk assessment had been completed by an external company on 28 July 2014. Issues were identified with piping on the boiler and as a result an engineer attended on 14 October 2014 to address this.

Equipment

The practice building was owned by a charitable housing trust, and maintenance was shared between the practice and the landlords. The deputy practice manager was responsible for arranging maintenance repairs and they had an onsite handyman to carry these out. Calibration checks of medical equipment kept by the practice were performed annually. Portable Appliance Testing (PAT) and Medical Equipment Certificates were seen and valid from February 2014 to February 2015. These showed that medical equipment such as blood pressure monitors, medical scales and thermometers had been tested and corroborated. The practice fire extinguishers had been checked and serviced in March 2014.

Good

Are services safe?

Staffing and recruitment

The practice had a recruitment policy and appropriate pre-employment checks had been carried out prior to new staff commenced work at the practice. These included confirmation of relevant qualifications, registration with professional bodies, photographic identification, Disclosure and Barring Service checks and two references. Clinical staff records we reviewed confirmed the presence of these documents. None of the administration staff had DBS checks completed but were told the practice was completing a risk assessment to review the need for these.

The practice had procedures to follow in the event of staff absence to ensure smooth running of the service. The practice aimed to maintain five administration staff during the morning and six staff in the afternoon. We were told that staff had to inform the practice management of any absence before six am on the day they were due to work and then call again by 6pm that day to discuss returning to work. The deputy practice manager arranged clinical cover with locum agencies.

Monitoring safety and responding to risk

Processes were in place for monitoring safety and responding to risk. The practice had a Health and Safety Policy dated 2011 that covered a range of information including where first aid kits were stored and fire safety. A Health and Safety Risk Assessment was performed twice a year. We reviewed the most recent risk assessment from March 2014 and saw it included an action plan with timescales, for example putting a sign on the lift to indicate what to do in the event of an emergency which had been addressed.

We were told by the deputy practice manager that the landlord of the premises had taken over management of fire safety for the building in 2010 and that they performed fire alarm testing monthly. The practice had a named lead for fire evacuation and a named fire marshal; however a fire evacuation drill had not been performed since 2010.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all clinical and administration staff were up to date in basic life support training. Emergency equipment was kept on a trolley in the ground floor nurses room and included an oxygen cylinder, adult and paediatric masks and resuscitators. We were advised after the inspection that the practice had purchased an automated external defibrillator (used to attempt to start a person's heart in an emergency). Laminated protocols for dealing with medical emergencies including cardio pulmonary resuscitation (CPR), anaphylaxis, choking, cardiac chest pain and meningitis were kept with the emergency trolley.

Emergency drugs were stored in the same room as the emergency equipment and included those for the treatment of cardiac arrest, anaphylaxis, hypoglycaemia and asthma attacks. A weekly process was in place to check that emergency drugs were within their expiry date and emergency equipment was fit for use. We saw that the emergency drugs kept were all within their expiry dates.

The practice had a policy for 'Dealing with Disaster and Recovery' updated in October 2014. The policy details covered procedures to follow in the event of significant disruption to services, for example loss of building, telephone system or computer system and contained relevant emergency numbers. The practice had used the policy in July 2014 in response to a flooding in the ground floor of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided care in line with national guidance. They were familiar with current best practice guidance and had access to guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. GP's had access to Camden Clinical Commissioning Group (CCG) care pathways in the electronic patient notes system which provided prompts and allowed them to write care plans for patients. New guidelines from NICE and the CCG were disseminated to clinical staff electronically and were discussed at weekly clinical practice meetings. We saw minutes of a recent clinical meeting at which new CCG guidance and a template on unplanned hospital admissions had been discussed and action plans documented. Minutes of clinical meetings were sent to all staff electronically.

GPs we spoke with told us they led in specialist clinical areas including diabetes, hypertension, chronic obstructive pulmonary disease (COPD), asthma and mental health. The practice employed a nurse practitioner whose role included supporting patients with long term conditions such as diabetes, COPD/asthma and hypertension. Clinical staff we spoke with were open about asking for and providing colleagues with support. All trainee GPs had a named supervising GP for support and salaried GPs had a mentor to seek advice from.

A GP partner showed us data from the CCG indicating good performance, for example blood pressure recording was above the local CCG average for patients with long term conditions including chronic kidney disease, hypertension, diabetes and heart failure. We were shown the process the practice used to review patients recently discharged from hospital, which involved the discharge letter being scanned into the electronic notes and allocated to a GP on the same day to review and action according to individual patient need.

All GPs we spoke with used national standards for referral, for example referrals for suspected cancer seen within two weeks. We were told all referrals were made using the Choose and Book system and were subject to review by the Camden Clinical Assessment Service (CCAS) who vetted referral letters and directed them to the most appropriate service. The practice received feedback from the NCAS if any referrals had been rejected or re-directed to another service and this was used to improve future practice.

The practice was involved in the recruitment of patients to the national research project CANDID (Clinical prediction rules for colorectal and lung cancer) co-ordinated by the University of Southampton. The aim of the study was to evaluate which of the symptoms and examination findings are the most effective in predicting lung or colon cancer. The study recruited patients who consulted their GP with lung or low bowel symptoms.

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

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management.

The practice showed us ten clinical audits that had been undertaken in the last four years. One of these was a closed loop audit on prescribing of nutritional supplements where the practice was able to demonstrate changes resulting since the initial audit. The initial audit completed in 2011 showed the practice was performing below required standards in several areas including documentation of weight and height in patients receiving nutritional supplements and in the number of patients who received regular reviews. GPs were provided with education on the guidelines for prescribing nutritional supplements as part of the action plan from the initial audit and subsequent re-audit completed in 2012 showed the practice had improved. For example, all patients who received nutritional supplements were reviewed every three to six months. GPs that we spoke with us told us all GP trainees were required to complete an audit and present it at the practice meeting during their training year.

Clinical audits were often linked to medicine management information, Quality and Outcomes Framework ((QOF is a voluntary incentive scheme for GP practices in the UK. The

Good

Are services effective?

(for example, treatment is effective)

scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures) and Clinical Commissioning Group (CCG) monitoring. For example, data was gathered by the practice for the CCG and London Cancer Partnership on diagnosis of bowel cancer in their patients to identify if there had been any delays in diagnosis and treatment. The practice also undertook a CCG led audit on monitoring of Methotrexate, a medication used in rheumatoid arthritis. This found that although patients who were prescribed the medication were being regularly reviewed, not all were having blood tests checked as frequently as recommended by national guidance. This was used to educate GPs and improve practice.

There was a protocol for repeat prescribing which was in line with national guidance. All repeat prescriptions had a review date and if this date had passed administration staff would inform the relevant GP for review. The practice had in-house alerts on the IT system for prescriptions of medicines they wanted to control, for example some types of antibiotics. These alerts would flag up when a GP tried to prescribe such medicines and required them to review the prescription.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance date from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area. For example, they had similar flu vaccination uptake rates to comparable GP practices in the area and were performing better than the average for prescription of non-steroidal anti-inflammatory drugs (a type of pain killer).

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory training including basic life support. A good skill mix was noted amongst the doctors including one salaried GP with an MSc in Information Technology Management. The practice also employed a nurse practitioner. All GPs were up to date with their yearly continuing professional development requirements and three of the four GP partners had been revalidated and the fourth was in the process of revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented and timelines for completing these agreed. There was a lead GP for appraisals, salaried GPs were appraised by GP partners and the practice manager conducted the administration staff appraisals. We reviewed the appraisal matrix which confirmed all staff had been appraised in July 2014 apart from two who were new starters to the practice. For example, the practice arranged an in-house training session on dealing with aggressive patients after this was identified as a learning need by several members of the administration team. Staff confirmed the practice was proactive and funded relevant courses, for example a member of staff was completing a phlebotomy course. As the practice was a training practice, GP trainees were offered extended appointments and all trainees had access to a senior GP supervisor. The GP trainees had weekly tutorials and there was a monthly trainers meeting to discuss any issues raised at these sessions. Feedback from those trainees we spoke with was positive.

Practice nurses had defined duties and they were able to demonstrate they were trained to fulfil these duties, for example in the administration of vaccines, travel advice and cervical cytology. The nurse practitioner had additional roles, including managing patients with long term conditions, and could demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X-ray results and letters from local hospital and out of hours services were received electronically. Some urgent results were received by fax and these were scanned by administrative staff and directed to the GPs. Staff we spoke with were aware of their roles and responsibilities for passing on, reading and responding to any issues from communications with other care providers.

The practice held bi-monthly multi-disciplinary team meetings with each of the Camden and Brent borough support services to discuss the needs of complex patients and create shared care plans for their management. These meetings were led by one of the GP partners and attended

Good

Are services effective?

(for example, treatment is effective)

by the practice clinical team, district nurses, health visitors, physiotherapists, occupational therapist and palliative care nurses. There was a schedule of external experts in a range of professions to attend these meetings and give teaching presentations to the multi-disciplinary team.

The practice had access to mental health services to help support and manage patients with mental health issues. This included access to the Camden Improving Access to Psychological Therapies (IPAT) Service. A mental health worker and clinical psychologist from IAPT offered cognitive behavioural therapy (CBT) at the practice and also offered online support. Patients could self-refer to this service.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, the practice received information from the out of hours provider via the computer system and this was passed to the duty doctor to follow up on. The administration staff provided the out of hours services with the duty doctor rota one month in advance and a list of patients who received palliative care. Electronic systems were in place through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and book their own outpatient appointments in discussion with their chosen hospital). All referrals made were reviewed by the Camden Clinical Assessment Service (CAS) and any rejected referrals were returned to the referring GP with feedback. The deputy practice manager and three administration staff were trained to use Choose and Book and they reported no issues with the process.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 following training that had been arranged by the practice. Clinical staff we spoke with understood the key elements of the legislation and their responsibilities to enact this. We were shown examples of how patients with learning disabilities had been supported to make decisions about their care plans through the use of pictures to help convey the information given. For example, the practice had adapted guidance from the Royal College of General Practice (RCGP) when inviting patients with known learning disabilities for an annual health check through the use of pictorial explanation of the process.

The practice had procedures for documenting consent for specific interventions. For example, written consent was obtained for minor surgery. For contraceptive implants and intra-uterine contraceptive devices (IUCD) verbal consent was documented in the patient's electronic notes.

Health promotion and prevention

The practice had a policy to offer all new patients who registered with the practice a health check with the health care assistant (HCA). The GP was informed of all health concerns detected and these were followed up in a timely manner.

The practice had numerous ways of identifying patients who needed additional support and were pro-active in offering help. For example, the practice kept a register of all patients with learning difficulties and invited them for an annual check including medication review and blood tests if required. The practice provided support to patients wishing to stop smoking. They ran a smoking cessation service led by the HCA and used a data collection and reporting resource to provide advice and support. We were told that the practice achieved the highest smoking quit rates of GP practices in the local Clinical Commission Group (CCG) area. Data from the Quality Outcomes Framework (QOF) showed the practice was in line with other GP practices in the local CCG area in offering patients with long term conditions support to give up smoking.

The practice performance for cervical smear uptake was 74% for 2013 - 2014 which was comparable with other practices in the local CCG area. Practice nurses were trained in performing cervical smears. The practice nurses were also trained in family planning and one of the salaried GPs had set up an intra-uterine contraception device (IUCD) clinic to meet the needs of women of reproductive age at the practice.

The practice offered a full range of immunisations for children, travel and flu vaccinations in line with current national guidance. The performance in uptake of childhood immunisations by age one year was 98% and by two years was 92% which was better than the local CCG average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we observed staff to be kind, friendly, and respectful towards patients attending the practice and when speaking to them on the telephone. Patients we spoke with were complimentary about practice staff and said they were treated compassionately, with kindness and respect. Many of the completed Care Quality Commission (CQC) comment cards we received referred to staff as friendly, professional, caring and helpful.

Evidence from the latest GP national patient survey published by NHS England July 2014 showed that patients were satisfied with how they were treated. Eighty-two per cent said that the last GP they saw or spoke to was good at treating them with care and concern and 89% found the receptionists helpful. The practice was above average in the Clinical Commissioning Group (CCG) area for its satisfaction scores on consultations with doctors. Ninety-one per cent of respondents said they had confidence and trust in the last GP they saw or spoke to and 85% said that their GP was good at listening to them.

Patients told us privacy and confidentiality was maintained during consultations. We noted that surgery room doors were closed during consultations and conversations could not be overheard on the ground floor consultation rooms. However, sound was audible from the consultation rooms upstairs and some conversations could be overheard. Following our visit the practice advised us that the upper floor consultation rooms had now been soundproofed. We also observed that the specimen drop off box in the reception area was inappropriately positioned as information on some samples inside could be seen.

Reception staff undertook a continuous programme of customer care training and development which included learning from actual scenarios of patient encounters for example. The practice had a chaperone policy and information about chaperoning was displayed in consulting rooms. Patients had the option to see a male or female GP when booking an appointment.

Care planning and involvement in decisions about care and treatment

The results of the GP national patient survey showed that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. For example, 71% of respondents said the last GP they saw involved them in decisions about their care and 83% felt the GP was good at explaining treatment and results. Seventy-four per cent of respondents said the last nurse they saw was good at giving them enough time and 75% said the nurse was good at listening to them.

Patients we spoke with during our visit told us they felt involved in decision making about the care and treatment they received and that GPs explained results and treatment options well to help them make informed choices. Patient feedback on CQC comment cards we received reflected this feedback.

Staff told us that they booked a face-to-face interpreter and a double appointment for patients who did not speak English as their first language, so that patients could be involved in decisions about their health care and to obtain informed consent. A telephone translation service was also available in an emergency or when an interpreter was not available. Patients told us staff respected and supported their religious and cultural needs.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with were positive about the emotional support provided by the practice. CQC comment cards we received reflected this feedback. Information in the waiting room and on the practice website sign-posted patients to a number of support groups and organisations, such as alcohol services to support people experiencing difficulty with alcohol use, direct access physiotherapy services and services for carers.

The practice kept a register of patients who were carers. The practice computer system alerted GPs if a patient was a carer. The Care Co-ordinator had received additional training in 'Caring for Carers' to help them support carers as well as patients.

The practice maintained a list of all patients who received palliative care and this was shared with the out-of-hours care provider. Bi-monthly multi-disciplinary team (MDT) meetings attended by the community palliative care nursing teams were hosted by the practice to discuss patients and their families care and support needs. All practice staff were informed when a patient had died and a protocol was in place for staff to follow. This included

Good

Are services caring?

informing other agencies and professionals who had been involved in the patient's care, so that any planned appointments, home visits or communication could be cancelled.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. For example, the practice used a risk stratification tool for hospital admissions to identify patients at risk of unplanned admissions and prevent unwanted outcomes.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice told us they had close links with the CCG and until July one of the GP partners had been on the CCG board.

There had been little turnover of staff during the last three years which enabled good continuity of care. We were told several of the GPs had trained at the practice and had returned to work there once they had qualified. Longer appointments were available for those who needed them and patients had a choice to see a male or female GP. Home visits were available for patients unable to attend the practice and GPs conducted approximately four to five of these visits a day.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, the PPG identified issues with hygiene in the toilets and as a result hand towels were replaced with hand dryers. The PPG also raised issues with telephone access and in response the practice increased the number of receptionists available to answer phones and opened the telephone lines for longer.

The practice kept a palliative care register and held monthly multi-disciplinary meetings either with Camden or Brent palliative care team to discuss the needs of these patients and their families. Information was shared with the out-of-hours care provider. Whilst the practice was not formally accredited to the Gold Standard Framework (GSF) for end of life care, they were signed up for Camden End of Life of Care local enhanced services and had received a satisfactory review in December 2014.

The practice had recently employed a care co-ordinator to support the practice in meeting the needs of the practice population. This role included identifying and arranging appointments for patients who needed regular review, such as annual checks of blood pressure or long term condition checks and patients who required medication review. The role also involved a daily record search of patients due to attend the practice the following day, or those attending on the day to identify if any additional input was required for example, flu vaccination or asthma review. For those patients identified an alert was flagged in the patient's record so that the appointed GP or nurse was made aware.

The practice reviewed and updated the care plans of patients who had required emergency admission to hospital. At the time of our visit 84% of care plans had been reviewed and updated for patients with complex needs.

All patients over the age of 75 years had a named GP. The practice kept a register of frail elderly patients at high risk of hospital admission and those receiving end of life care. The practice hosted bi-monthly multi-disciplinary team meetings separately with Camden and Brent community nursing teams to discuss and update care plans for complex elderly patients. The practice was accessible to patients who may have difficulty walking with ground floor clinics and a lift available to consultation rooms on the first floor. The practice invited patients with long term conditions such as asthma/chronic obstructive pulmonary disease (COPD), diabetes and high blood pressure for annual review. A record of annual diabetes checks performed was kept electronically and the practice demonstrated good performance in this area with 80% of diabetic feet and eye checks completed. Patients with long term conditions had a named GP and were able to make pre-bookable appointments to see their doctor. GPs could refer patients to the expert patient program which was a self management course to help patients take control of their health.

The practice held a weekly 'one stop shop' baby clinic with the GP and health visitor. This clinic provided postnatal checks, immunisations and baby checks. The uptake rates of child immunisation were better than the local CCG average with a 90% uptake at two and five years of age. We were told by staff that the triage system provided quick access to a GP if a child was brought into the surgery unwell. The practice nurses had been trained in family planning and one of the GP partners had set up an Intra-uterine contraceptive device (IUCD) clinic.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had extended opening hours to ensure people of working age and in full time education had access to appointments. They offered health checks to new patients and reported uptake rates of over 90%.

The practice kept a register of patients with learning disabilities and all these patients were personally invited to attend an annual review in the format of an easy to read pictorial letter that encouraged patients to bring their carers to the appointment. At the time of our visit 90% of these reviews had been completed. Staff told us they worked closely with local learning disability leads to ensure that the register was up to date and information correct. The practice kept a register of patients who were carers and this was flagged on their electronic records to alert staff when they attended an appointment.

The practice had a register of patients experiencing poor mental health and 90% of these patients had written care plans agreed. These patients were invited to annual assessments including medication review, blood tests to monitor medication levels, and physical health checks including blood pressure. The practice had access to an in house substance misuse and alcohol abuse service and Improving Access to Psychological (IAPT) services. The Camden Community Mental Health Team (CMHT) visited the practice regularly to provide support and advice on complex patients experiencing poor mental health who lived in the London Borough of Camden. This service was not available for patients residing in the Brent borough.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They had access to face-to face interpretation services for patients who did not have English as their first language. Some members of staff were also able to assist in translating some languages if required. A double appointment was arranged when an interpreter was needed.

The practice had an equality and diversity policy and this was provided to all new staff as part of their induction programme. The policy was accessible to all staff to refer to.

The premises had been adapted to meet the needs of people with disabilities. For example, there was lift access to the first floor, disabled toilet facilities were available and there was a hearing loop in reception for patients with hearing difficulties.

Access to the service

Appointments were available from 8.00am to 1.30pm and 2.00pm to 6.30pm Monday to Fridays. Extended hour appointments were available between 7.30am to 8.30am on Mondays and between 6.30pm and 8.00pm on Tuesdays and Thursdays. The telephone line opening hours were between 8.00am and 6.30pm Mondays to Fridays. Telephone calls were recorded and monitored for quality and training purposes.

Details of the practice opening hours were available to patients on the practice website. Information included how to arrange an urgent appointment and home visits and how to book appointments through the website. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answer phone message that provided the telephone number to call if medical assistance was required.

Patients we spoke to were generally satisfied with the appointment system and felt they could get appointments easily when required. Some negative feedback received commented on waiting a long time for the telephone to be answered when ringing to make an appointment. Data from the National GP Patient Survey 2014 showed 70% of respondents described their experience of making an appointment as good and 84% said they were able to get an appointment to see or speak to someone the last time they tried.

The practice had won an Innovation Fund bid to improve telephone access to the practice with the aim of reducing accident and emergency attendances. Previously the practice telephone lines were closed over the lunch time period but the funding had enabled the practice to employ additional reception staff to allow them to keep lines open at lunch time. The practice ran a pilot of the lunch time telephone service between November 2013 to March 2014. An analysis of the results by the practice had shown that there had been 85 less accident and emergency attendances per month for the three months from November to January. The funding for this service ceased in March 2014 but as the results had been positive the practice continued to fund the additional staff to allow lunch time telephone access to continue.

The practice was the first GP surgery in Camden to pilot 'Patient Partner' - a system that enabled patients to book, cancel and check appointments using their telephone

Good

Are services responsive to people's needs?

(for example, to feedback?)

keypad. The system was available 24 hours a day and was designed to improve patient access, reduce missed appointments and relieve some of the pressure on the practice telephone system at busy times.

Extended hour appointments and ability to book appointments online facilitated access to appointments for people of working age or full time education. Home visits were available for elderly patients and those with long term conditions unable to attend the practice. Patients were sent text message reminders of appointments.

The practice was situated on the ground and first floor of the building with lift access. We saw the waiting area was large enough to accommodate patients with wheelchairs and prams. Accessible toilet facilities were available for all patients attending the practice including baby change facilities.

Listening and learning from concerns and 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 received by the practice. Written complaints were sent to the deputy practice manager who would acknowledge receipt of the complaint within three working days. The practice aimed to have the complaint investigated within ten working days and then to issue a formal written response which included details of the right to escalate the matter further if unsatisfied with the response.

We saw that information was available to help patients understand the complaints system including a complaints information leaflet, information displayed on the television screen in the waiting room and information on the practice website. One of the GP partners was the clinical lead for complaints and the practice manager and deputy practice manager the non-clinical leads. We reviewed the practice's complaints procedure and saw that it matched information provided to patients.

We looked at 11 complaints received in the last 12 months; five complaints related to clinical issues and six to administration or procedural issues. All complaints had been dealt with and resolved in a timely way. The practice kept a spread sheet of complaints including the name of the person responsible for investigating the issue, the dates of resolution and learning points from the complaint. Staff told us they found the telephone monitoring recording system had been useful in learning from issues and complaints. For example, a patient had complained about a member of reception staff during a telephone call and when listening back to the call with the deputy practice manager, the member of staff was able to identify areas of improvement for future communications. Telephone recordings were also used as real life scenarios during team training.

The practice reviewed complaints annually to identify any themes and trends and this information was presented to the Clinical Commissioning Group. Individual complaints were discussed individually at the weekly practice meetings.

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

Staff told us the practice vision was to put patient care first and ensure access to high quality care. We saw the practice had a 'Blue Skies Thinking' document which outlined the five year plan for the practice including managing an increasing patient list and planning for upcoming staff retirements.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the practice intranet. All staff had signed a record sheet to confirm they had read these policies and knew where they were stored on the shared drive.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at team meetings to identify areas for improvement.

The practice had completed a number of clinical audits to monitor performance and improve services. For example, a closed loop audit on prescribing practices for nutritional supplements found that best practice guidelines were not being followed. Staff were provided with education and awareness training on this issue and the subsequent audit showed improved results.

The practice had robust arrangements for identifying, recording and managing risks. There was an incident and accident book in the reception area that had recorded incidents for the last five years. All incidents were reviewed and discussed annually to produce a significant incident analysis report that highlighted trends and areas for learning and improvement.

Leadership, openness and transparency

We saw the practice's documented leadership structure which had named members of staff in lead roles. For example, one of the GP partners was the lead for infection control, there was a clinical and administration lead for complaints and one of the GPs was the lead for safeguarding. Staff we spoke with told us there was a strong management team and that they felt well supported.

The four GP partners and two practice managers met weekly to discuss management issues. We saw the minutes for the two recent management meetings which included documentation of matters to be resolved and an action log.

The practice had a number of human resource policies and procedures including staff absence and disciplinary procedures. These were available on the practice intranet and staff handbook.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, NHS choices and complaints. We looked at the results of the annual patient survey completed in February 2014. The comfort of the waiting room scored 56% which was below the national average mean score of 66% with some patients specifically mentioning in the free text section of the survey that toilet facilities could be improved. As a result of this feedback the practice had installed hand driers instead of paper towels as requested by patients. The action plan to address this feedback also included plans for reception staff to monitor the toilet facilities throughout the day to ensure they were fit to be used, notice boards in the waiting room to be de-cluttered and new seating to be arranged for the upstairs waiting room.

The practice had an active patient participation group (PPG) with thirty six members; 25 female and 11 male with representation from each age group from 20 years to over 65 years. The PPG recruited members using a variety of advertising in order to improve representation of the practice population including on the practice website, information on prescriptions and on information screens in practice waiting rooms. The practice was also involved in the development of a west locality alliance of PPGs, with the aim of strengthening the patient and carer voice. The PPG carried out regular patient surveys and we were shown the analysis of the most recent survey focusing on information delivery and the practice website. This found of the 345 respondents 22% used the practice website and following this an action plan was made to improve promotion of the website and review the information it provided.

The practice had gathered feedback from staff through staff meetings, staff appraisals and team away days or social

Are services well-led?

Good

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

events. Staff told us they were happy to articulate any feedback they had to the management team. The practice had a whistle blowing policy which was available to all staff in the staff handbook and on the practice intranet.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We reviewed staff files and saw that appraisals took place annually and included a personal development plan.

The practice was a training practice and employed five GP trainees. The GPs at the practice held important roles in education, one of the GP partners was a local training programme director for GP training and one of the salaried GPs had a role in supporting trainees in difficulty. The GP trainees spoke highly of the practice stating it had a good reputation for training and was educational. Every trainee had a named GP supervisor who was available to give advice and support if required during consultations. The practice held monthly teaching meetings for the trainees which included attendance by external trainers from other practices.

The practice had completed reviews of significant events and other incidents and shared learning from these with staff via meetings to ensure the practice improved outcomes for patients. For example, during a medical emergency in the waiting room there was difficulty accessing the room where the emergency trolley was kept because the keypad to the door was broken and it was noted there was some confusion as to which doctor was the lead in managing the emergency. This event was discussed and reflected on in the practice meeting and as a result the keypad to access the room with the emergency trolley was repaired and there was a plan to identify a lead GP in emergency settings. The practice team agreed to arrange emergency practice sessions with all the GP team to ensure these procedures were understood.