The Lonsdale 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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Lonsdale Medical Centre on 23 February 2016. The practice was rated as requires improvement for providing safe, services, good for providing effective, caring, responsive and well-led services and an overall rating of good. The full comprehensive report of the 23 February 2016 inspection can be found by selecting the 'all reports' link for on our website at www.cqc.org.uk.

This inspection was carried out to check that action had been taken to comply with legal requirements, ensure improvements had been made and to review the practice's ratings. Overall the practice is now rated as good.

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

- The practice team included a GP with an advanced qualification in mental health and this GP had helped to develop a range of protocols which improved the care and treatment given to patients with mental health conditions.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Continue to action areas for improvement identified in the infection prevention and control audit.
- Continue to monitor uptake rates for public health screening programmes, particularly breast cancer screening, with a view to improving uptake rates.
- Continue to review patient satisfaction levels around access to services and improve processes for making appointments.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- When we inspected in February 2016, we found the practice had not carried out a recent fire risk assessment and could not provide records of regular fire drills. When we inspected in July 2017, we saw that the practice had an up to date fire risk assessment and had carried out regular fire drills. There were designated fire marshals within the practice and a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- During our inspection in February 2016, we noted that although an infection prevention and control audit had been carried out, there were no records to demonstrate that recommended action points had been followed through. At this inspection, we saw that the most recent annual IPC audits had been undertaken in July 2017 and we saw that the practice had developed an action plan to address improvements identified.
- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- The practice used innovative and proactive methods to improve patient outcomes including for instance, using an electronic diary management system to ensure that patients who needed follow-up appointments received and attended them.
- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care in innovative and efficient ways. For instance, the practice hosted meetings of the multi-disciplinary Complex Patient Management Group and used these meetings to plan care for patients.
- The practice team included GPs with special interest in cancer care and the treatment of mental health conditions and these GPs were available to provide specialised advice to other clinicians.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice as comparable to others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Patients could choose to be emailed copies of letters sent to other care providers enabling them to be more involved in planning their own care and to feel reassured that referrals had been made.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.

Summary of findings

- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services, for instance with the local Short-Term Assessment, Rehabilitation and Reablement Service (STARRS).
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- Patients aged over 75 years were able to by-pass the main telephone switchboard to ensure they received a more responsive service.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators were above CCG and national averages. For instance, 92% of patients had well controlled blood sugar levels (CCG average of 77%, national average 78%). The percentage of patients on the diabetes register with well controlled cholesterol was 88% (CCG average 80%, national average 80%).

Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All patients had a named GP and the practice used an electronic diary management system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Patients could choose to be emailed copies of letters sent to other care providers enabling them to be more involved in planning their own care and to feel reassured that referrals had been made.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice provided support for premature babies and their families following discharge from hospital.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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).

Summary of findings

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice provided an online e-consultation system and this was helpful to some patients who found it difficult to attend the surgery during working hours.
- The practice was a member of a primary care cop-operative and had dedicated appointment slots available at a local hub until 9:00pm every evening as well as at between 9am and 3pm on Saturdays and between 9am and 1pm on Sundays. These appointments were available with GPs and nurses, included childhood immunisations and cytology, and could be booked in advance.
- The practice was proactive in offering online services and over 80% of the practice had registered for an online account.
- The practice allowed students who have moved away from home to register as temporary patients during holiday time. People visiting or working locally for short periods could also be registered and seen in this way.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability. Patient who were homeless were able to register at the practice address.
- The practice used an electronic diary management system to plan and monitor key dates for patients including follow-up appointments, test results and referrals. Patients with appointments falling due or who required blood tests were contacted and reminded and this helped patients with impaired cognition and those with memory loss.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Summary of findings

- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- One partner had a special interest in mental health, including psychopharmacology and evidence-based nutritional approaches to mental health. This GP provided an expert service for patients with unstable and severe mental health problems and worked with GP colleagues in-house and providing bespoke management plans.
- We looked for evidence of impact and noted that performance for mental health related indicators were above CCG and national averages. For example, 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record compared to the CCG average of 91% and national average of 89%. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 92% (CCG average 86%, national average 84%). The uptake rate for cervical cytology screening by eligible women with schizophrenia, bipolar affective disorder and other psychoses was 89% (CCG average 87%, national average 89%).
- The practice had developed links with secondary care providers, including cardiology specialists and hospital pharmacists to improve monitoring of patients taking medicines to treat mental health conditions whilst also prescribed medicines for high blood pressure. We saw two examples where the practice had identified lithium toxicity due to hospital initiated blood pressure medicines and had been able to help the patients to access emergency care. In both cases the practice had contacted the hospital to share their learning and had worked with the hospital to review their own procedures.

Summary of findings

- The practice had developed a protocol through which every GP at the practice received a monthly mental health patient report. This report provided patient's usual doctor with details of all health or medicine reviews falling due within the coming month as well as details of most recent pathology results and when blood tests were due to be repeated.
- Patients with the most complex mental health conditions were able to book joint consultant and GP appointments at the practice.
- 92% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which above the national average.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs and had worked with the Institute of Psychiatry to improve how lithium usage was monitored in general practice.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia. Patients with the most complex mental health conditions could have joint appointments with their GP and a consultant psychiatrist.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and ninety four survey forms were distributed and 108 were returned. This represented 1% of the practice's patient list.

- 81% of patients described the overall experience of this GP practice as good compared with the CCG average of 80% and the national average of 85%.
- 60% of patients described their experience of making an appointment as good. (CCG average 68%, national average 73%).
- 72% of patients said they would recommend this GP practice to someone who has just moved to the local area (CCG average 72%, national average 80%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 12 patient Care Quality Commission comment cards, most of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. However, three cards included less positive comments around the appointment system with patients highlighting difficulties getting appointments and delays in the waiting area.

We spoke with three patients during the inspection. All three patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice participated in the Friends and Family test; results showed that 76% of patients stated they were either 'extremely likely' or 'likely' to recommend the practice.

Areas for improvement

Action the service SHOULD take to improve

- Continue to action areas for improvement identified in the infection prevention and control audit.
- Continue to monitor uptake rates for public health screening programmes, particularly breast cancer screening, with a view to improving uptake rates.
- Continue to review patient satisfaction levels around access to services and improve processes for making appointments.

The Lonsdale 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 specialist adviser.

Background to The Lonsdale Medical Centre

Lonsdale Medical Centre provides GP primary care services to approximately 14,500 people living in Queens Park, London Borough of Brent.

There are currently six full time GP partners, four male and two female and one salaried GP who provide a combined total of 36 sessions per week. The practice is a GP training practice with two trainees in place at the time of our inspection. The trainees undertake a combined total of approximately 12 sessions per week. The practice is also a training practice for physician associates.

There is a practice nurse, a healthcare assistant who is also a phlebotomist (Phlebotomistsare specialist clinical support workers who take blood samples from patients) a practice manager and thirteen administrative staff. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practice opening hours are 8:00am to 6.00pm between Mondays and Fridays. The practice is closed on Saturdays and Sundays. Telephones are answered between 8:00am and 1pm and 2pm 6:30pm daily. GP and nurse appointments are available between 9:00am and 1:00pm and 2:00pm and 6:00pm daily.

The practice is a member of The Kilburn Primary Care Co-op and has dedicated appointment slots available at a local hub until 9:00pm every weekday evening as well as at weekends between 9:00am and 3:00pm. These appointments are available with GPs and nurses, include childhood immunisations and cytology, and can be booked in advance.

The practice has opted not to provide out of hours services (OOH). Patients needing urgent care when the practice is closed are advised to contact the OOH number 111 which directs patients to a local contracted OOH service or Accident and Emergency, depending on patients' medical urgency.

The practice population comprises of fewer patients over 65 years of age (8%) than the CCG average of 10% and the national average of 17%, and more patients under 18 years of age (25%) than the CCG average of 19% and the national average of 21%.

Information published by Public Health England rates the level of deprivation within the practice population group as five on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. This information also shows that although the deprivation score for the practice profile as a whole has improved between 2012 and 2015, Income Deprivation Affecting Older People (IDAOPI) is higher (29.4%) than the CCG average of 28% and the national average of 16.2%. Average life expectancy is higher than the national average for males and females at 82 years and 87 years respectively.

The practice caters for a lower proportion of patients experiencing a long-standing health condition (37%)

compared to the local average of 50%. The proportion of patients who are in paid work or full time education is higher (74%) than the CCG average of 67% and the national average of 62% and unemployed figures are significantly lower, 5.7% compared to the CCG average of 8.4%.

The practice provides level access to the building and is adapted to assist people with mobility problems. All treatment and consulting rooms are fully accessible including those on the first floor which is accessible by a lift.

The borough of Brent is ethnically diverse and the practice population reflects this diversity. In the latest census in Brent, 36% gave their ethnicity as white, 35% as Asian, 20% as Black and 4.5% as of mixed or multiple ethnicities, the remainder identifying as Arab or other ethnicity.

Why we carried out this inspection

We undertook a comprehensive inspection of The Lonsdale Medical Centre on 23 February 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for providing safe services. Overall the practice was rated as good. The full comprehensive report following the inspection on 23 February 2016 can be found by selecting the 'all reports' link for The Lonsdale Medical Centre on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of The Lonsdale Medical Centre on 26 July 2017. This inspection was carried out to review the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 26 July 2017. During our visit we:

- Spoke with a range of staff (three GPs, practice manager, practice nurses and reception manager) and spoke with patients who used the service.
- Spoke with staff from Kilburn Primary Care Co-Op Limited. (Kilburn Primary Care Co-Op Limited is a not for profit social enterprise created by twelve general practices in south Brent and provides a range of services on behalf GPs behalf, including extended hours surgeries, anticoagulation clinics, dementia services and integrated care management).
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

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.

Good

Are services safe?

Our findings

At our previous inspection on 23 February 2016, we rated the practice as requires improvement for providing safe services. We found that systems and processes to assess and manage risk to patients were not being implemented consistently, for instance, risks associated with fire safety. We also found that infection prevention and control audit records were not always updated when identified actions were completed and that recommendations contained in the Legionella risk assessment had not been reviewed or records kept of actions taken.

At this inspection we found that arrangements had improved significantly. The practice is now rated good for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of three documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an incident had been recorded where a GP had experienced a needlestick injury taking blood samples during a home visit. We saw records showing that the practice had undertaken an analysis of the incident and had assessed the impact of the incident on the GP, the patient and the practice. Following a review of the incident, the practice had identified that the protocol to manage a needlestick injury, whilst available had proved difficult to find when it was needed as were the contact details for the occupational health support which were required as a matter of urgency. As a result of the incident, the practice had moved the needlestick protocol to a more prominent location on a shared drive. Clinicans had also been provided with hard copies of the protocol so it was available during home visits. All staff had received a briefing which included refresher training around managing needlestick injuries and the protocol for managing sharps. This briefing had also been used to remind staff about the availability of occupational health support and in particular about the availability of immunisations and boosters for all staff.
- The practice also monitored trends in significant events and evaluated any action taken.
- We saw evidence that the practice submitted details of patient safety incident to the National Reporting and Learning System (NRLS). The NRLS is a central database which analyses safety incidents to identify hazards, risks and opportunities to continuously improve the safety of patient care.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level 3, the practice nurse and practice manager were trained to level 2, other members of staff were trained to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check.

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.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- One of the GP partners was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. The most recent annual IPC audits had been undertaken in July 2017 and we saw that the practice had developed an action plan to address improvements identified. For instance, the audit had found that not all clinical waste bins were foot operated and only two consulting rooms had sinks, taps and splashback areas which were fully compliant with best practice. We looked in three consulting rooms and saw that sinks in these rooms had overflow holes; taps that were not lever or sensor operated and tiled splashback areas. We saw that the practice had already placed an order to replace the waste bins and that a programme to refurbish clinical sinks was on the agenda for the next partnership meeting. We asked the practice how they mitigated against the risk of infection and were told that clinicians used paper towels when turning taps and that all plugs and chains had been removed and that the cleaning schedule included a protocol to ensure that tiled surfaces were cleaned with antibacterial cleaner.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- When we inspected in Februayr 2016, we found the practice had not undertaken a recent fire risk assessment and could not provide records of regular fire drills. At this inspection, we saw that the practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- During our inspection in February 2016, there were no records to show that all recommended actions contained in risk assessment for legionella had been taken.When we inspected in July 2017, we saw that a a risk assessment for legionella had been carried out recently and this identified a need to undertake regular water testing. We saw evidence that one member of staff had received appropriate training to do this and records indicated that weekly testing was being carried out using suitable testing equipment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Good

Are services safe?

- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

One of the GPs had a background in emergency and trauma medicine and they had a lead role in overseeing arrangements to respond to emergencies and major incidents. The practice was able to provide records of three recent occasions when clinicians had successfully managed medical emergencies on the premises, including instances of anaphylaxis and paediatric sepsis. (Anaphylaxis is an extreme and severe allergic reaction affecting the whole body, often within minutes of exposure to the substance which causes the allergic reaction (allergen) but sometimes after hours. Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs).

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks and we saw that there was a protocol in place to ensure these were checked weekly. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 23 February 2016, we rated the practice as good for providing effective services.

During this inspection, we found that the practice had maintained standards at this level. The practice is still rated as good for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 96% and national average of 95%.

The overall exception reporting rate for the practice was 8% which was comparable to the 6% CCG and national averages (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The exception reporting rate for diabetes was 22%, however the practice was able to provide evidence showing that although this was in part due to the high number of patients who were already receiving maximum tolerated doses of medication, there had also been a data error which had resulted in an inflated rate for this indicator. We saw current records which indicated that the current exception reporting rate for diabetes was 6% which was in line with local and national averages.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators were above CCG and national averages. For instance, 92% of patients had well controlled blood sugar levels (CCG average of 77%, national average 78%). The percentage of patients on the diabetes register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 88% (CCG average 80%, national average 80%).
- Performance for mental health related indicators were comparable to CCG and national averages. For example, 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record compared to the CCG average of 91% and national average of 89%. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 92% (CCG average 86%, national average 84%). The uptake rate for cervical cytology screening by eligible women with schizophrenia, bipolar affective disorder and other psychoses was 89% (CCG average 87%, national average 89%)
- 89 % of patients with hypertension had well controlled blood pressure compared to the CCG average of 83% and the national average of 83%.
- Outcomes for patients with asthma were above CCG and national averages. CCG and national averages. For instance, 91% had had an asthma review in the preceding 12 months using a nationally recognised assessment tool compared to the CCG average of 80% and the national average of 76%.

We asked the practice to tell us what actions they had taken to reduce the percentage of patients with long term conditions being exception reported. The practice told us they had undertaken an audit of all exception reported patients and had reviewed this audit clinician by clinician. The practice had held a special team meeting to review exception reporting protocols and had developed an electronic diary system to ensure that patients with long term conditions were invited to health reviews regularly throughout the year. This involved providing GPs and their allocated practice service professionals with a monthly list

Good

Are services effective?

(for example, treatment is effective)

of patients whose condition reviews were falling due or who had failed to attend previous reviews. Patients were contacted by telephone and invited to make appointments with the healthcare assistant, nurse or GP as appropriate.

There was evidence of quality improvement including clinical audit:

- There had been seven clinical audits commenced in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, the practice had undertaken an audit of patients with asthma who had been prescribed more than 12 short-acting reliever inhalers in the previous 12 months. This had been done with the aim of

of improving the management of asthma through education and change of treatment if required. During the first cycle undertaken in November 2016, the practice found that only 4% of patients with asthma had had their condition reviewed within the previous twelve months. Of those patients who had had an annual review, 93% had their inhaler technique reviewed during their annual review. As a result of the audit, all patients diagnosed with asthma had been invited to attend annual reviews. When the audit was repeated in June 2017, the practice found that the percentage of patients who had had an annual review had risen to 83%, although of the percentage that had their inhaler technique reviewed had reduced to 77%. Following the second audit cycle, the practice had arranged an educational session for clinicians to identify where further improvements could be made.

The practice was aware of the higher prevalence of cardiovascular disease amongst patients diagnosed with serious mental illnesses and had developed links with secondary care providers, including cardiology specialists and hospital pharmacists to improve monitoring of patients taking medicines to treat mental health conditions whilst also prescribed medicines for cardiovascular disease or high blood pressure. We saw two examples where the practice had identified lithium toxicity due to hospital initiated blood pressure medicines. In both cases the practice had contacted the hospital to share their learning and had worked with the hospital to review their own procedures

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- The practice had an electronic locum pack available. This included details of the electronic diary management system used by the practice, links to policies and procedures, for instance, policies governing repeat prescribing, tests and results and safeguarding. The pack also provided details of how the practice managed urgent cancer referrals, including an instruction to ensure that a GP partner was made aware of every such referral.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.
- Trainee doctors had weekly protected time for debriefing sessions with their trainers.

Coordinating patient care and information sharing

One of the practice GPs had a special interest in mental health conditions. They had developed a protocol through which every GP at the practice received a monthly mental

Good

Are services effective?

(for example, treatment is effective)

health patient report. This report showed the GP who was the usual doctor for each mental health patient, details of all health or medicine reviews falling due within the coming month as well as details of most recent pathology results and alerts to show when blood tests were due to be repeated. The patient's usual doctor worked with their dedicated practice service professionals to contact patients and invite them to make appointments. The practice told us this proactive approach had helped to improve the care of patients, and in particular patients with impaired cognition and those with poor memory.

The GP with a special interest in mental health worked closely with psychiatric specialists to develop personalised treatment which included pharmacological and behavioural treatments. For instance, we saw records showing that they had worked with a consultant psychiatrist to help patients improve their mental health not only by identifying the most suitable medicine but by providing advice around sleep management. For instance, we saw patient notes which showed that advice had been given about the benefit of developing sleep time routines combined with the use of special glasses which are considered helpful at improving nocturnal melatonin production. (Melatonin is a hormone that regulates sleep and wakefulness). Patients with the most complex mental health conditions were able to book joint consultant and GP appointments at the practice.

The practice had reviewed how work teams were structured in order improve cover arrangements during staff absence. Each GP had a dedicated administrative support team, known as Practice Support Professionals (PSPs). Historically, each GP and their team had a single 'buddy' GP who would provide cover when necessary. However, the practice had identified weaknesses in this system when a GP and their 'buddy' were away at the same time. The practice had responded to this by establishing two teams, each with a minimum of three doctors. This meant that there was always one doctor from both teams available and ensured that every patient was well known by more than doctor.

The practice had identified an opportunity to improve how patients were recalled for annual reviews and had developed an electronic diary management system to manage this. The practice referred to this as 'electronic safety netting' and as well as managing annual reviews, had built the system to monitor follow-up appointments, pathology tests, QOF reviews, high risk medicine reviews and urgent cancer referrals. The system involved using an electronic diary to alert staff when certain actions were due, for instance to check whether a patient had received and attended an urgent cancer referral appointment. GPs and their dedicated Practice Support Professional received weekly lists of all events about to fall due or any events which had remained outstanding from a previous period. Lists were sent to the Usual Doctor as well as to their named buddies and the system was searched weekly for any non-compliant actions.

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. The practice had put a process in place which involved clinicians and their dedicated administration support team being alerted by the computer systems when test results were due or had been received. As well as GPs having a 'buddy' each PSP also had a 'buddy' and the system had been designed to ensure that alerts were received by these also.
- From the sample of five documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice hosted and participated in monthly Complex Patient Management Group meetings. These meetings were attended by community based specialists, for instance, a consultant geriatrician, dementia and palliative nurses and integrated care management specialists. These meetings were minuted used to discuss the care of patients requiring additional support.
- The practice worked closely with the local short-term assessment, rehabilitation and reablement service (STARRS) and took a lead role in coordinating patient care between this team and the integrated care management team. The practice told us that this had improved care planning for patients at risk of unplanned hospital admissions and showed us evidence which indicated that the number of emergency hospital admissions for this group of patients had reduced from 61 in 2015/2016 to 33 in 2016/2017.

Good

Are services effective?

(for example, treatment is effective)

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and were able to access documents which provided guidance around Mental Capacity, Lasting Power of Attorney and Deprivation of Liberty as well as links to additional resources available online.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The GP with a special interest in mental health conditions had undertaken an advanced degree in Psychiatric Research and had published scholarly articles around Mental Health in the General Practice environment. They had also written or co-written articles about mental health for the medical press in this country and abroad and had been a contributor to national broadcast media in this field. This GP used this knowledge to support patients live healthier lives. For instance, we saw that they had undertaken research into the effects of diet on mental health conditions and in particular, into the effects of a low carbohydrate diet on persistent depressive disorder for their advanced qualification in Psychiatric Research. The practice had applied this research and was able to provide evidence of where changes in diet had contributed to improvements in outcomes for patients with mental health conditions including their physical health. For example, we saw records which showed that patients who had followed a healthier diet had been able to reduce the amount of medicine they needed to manage their condition.

The practice had contacted all patients prescribed with lithium to make them aware that a smart phone based lithium monitoring application had been developed by a local NHS Mental Health Trust and had explained how this help them monitor their lithium medication with greater ease than the existing paper based system. The practice had also worked with the Institute of Psychiatry to improve how lithium usage was monitored in general practice.

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- Smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 77% and the national average of 81%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. We saw that the practice had produced a practice specific letter to promote participation in the national bowel screening programme and this was sent to patients as they became eligible for the programme. The practice

Good

Are services effective?

(for example, treatment is effective)

uptake rate for bowel cancer screening was 57% which was comparable to the national average of 58%. The practice uptake rate for breast cancer screening was 56% which was lower than the national average of 73%. The practice told us that they would be adopting a similar approach to that used to promote bowel screening.

Childhood immunisations were carried out in line with the national childhood vaccination programme. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice had achieved the target in each of the four areas. These measures can be aggregated and scored out of 10, with the practice scoring 9.1 which was the same as the national average.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Agree good

Good

Are services caring?

Our findings

At our previous inspection on 23 February 2016, we rated the practice as good for providing caring services.

During this inspection, we found that the practice had maintained standards at this level and the practice is still rated as good for providing caring services.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

We received 12 patient Care Quality Commission comment cards, most of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. However, three cards included less positive comments around the appointment system with patients referring to difficulties getting appointments and delays in the waiting area.

We spoke with two patients, both of whom were members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. Results were broadly in in line with local and national averages. For example:

- 83% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 87%.
- 80% of patients said the GP gave them enough time (CCG average of 82% national average 87%).
- 93% of patients said they had confidence and trust in the last GP they saw (CCG average of 88%, national average of 92%).
- 82% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 81%, national average 85%).
- 88% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 91%.
- 87% of patients said the nurse gave them enough time (CCG average 86%, national average 92%).
- 97% of patients said they had confidence and trust in the last nurse they saw (CCG average 93% national average 97%).
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 84%, national average 91%).
- 83% of patients said they found the receptionists at the practice helpful (CCG average 84%, national average 87%).

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised. The practice told us that patients could choose to be emailed copies of letters sent to other care providers enabling them to be more involved in planning their own care and to feel reassured that referrals had been made.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

Good

Are services caring?

- 87% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care (CCG average 78%, national average 82%).
- 85% of patients said the last nurse they saw was good at explaining tests and treatments (CCG average 84%, national average 87%).
- 73% of patients said the last nurse they saw was good at involving them in decisions about their care (CCG average 78%, national average 85%)

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 291 patients as carers (2% of the practice list) and the practice was able to demonstrate that it had spoken with 227 (78%) of all carers at least once within the previous twelve months. The practice used their register to improve care for carers, for example carers were offered flexible appointment times, the seasonal influenza vaccination and an annual health check. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice had developed a bereavement protocol which was activated when the practice was informed of a patient's death. Reception staff would inform all staff involved in the care of the patient, including community based clinicians, for instance, specialist nursing teams and the locality manager. This reduced the risk that patient's relatives would receive potentially distressing letters or telephone calls inviting the deceased to appointments. Patient deaths were reviewed in primary care meetings to identify whether patients and carers wishes had been observed and to record learning points where this had not happened.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 23 February 2016, we rated the practice as good for providing responsive services although we noted that details of interpretation services were not clearly displayed and information about the complaints process was not advertised clearly.

During this inspection, we found that information about interpretation services and how to complain was available and that the practice had maintained other standards. The practice is still rated as good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice was a member of The Kilburn Primary Care Co-op; the practice had appointment slots available at a local hub until 9pm every evening, between 9am and 3pm on Saturdays and between 9am and 1pm on Sundays. These appointments were available with GPs and nurses, included childhood immunisations and cytology, and could be booked in advance.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice had 80% of its patients using a live online patient access account. The practice sent text message reminders of appointments and test results. The practice sent text message reminders of appointments and test results.
- Appointments could be booked and cancelled online and prescriptions requested through the website.
- Telephone appointments were available for patients who were unable to attend in person or whose needs meant they did not need to be seen in person.
- The practice provided electronic consultations with patients via a portal on the practice website. This could be used to access pre-prepared advice around a range of common conditions, to request administrative help or to seek the opinion of a doctor. Patients requiring a GP's advice were asked to complete a guided questionnaire regarding their condition and this was reviewed by a doctor who would decide on the appropriate course of action. This could include a doctor providing advice either by email or telephone, a prescription, or an invitation to make an appointment to see the doctor in person.
- Patients had access to a 'health pod'. This was a private room which was equipped to allow patients to record basic health check measurements (including blood pressure, height and weight) under the supervision of a member of the reception team, meaning this information was already available to a clinician when a patient attended their appointment. The practice encouraged its patients to use the practice's pod for self-monitoring of blood pressure.
- The practice did not offer travel vaccines but patients who required these were referred to other clinics. The practice website provided links to information about vaccinations needed for different parts of the world.
- There were accessible facilities, a lift, hearing loop, and interpretation services available.
- The practice has considered and implemented the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they can understand and receive appropriate support to help them to communicate.
- The practice website provided fact sheets in twenty locally prevalent community languages. This had been produced to help patients understand and navigate care options and to explain the role of the GP. The website also included a translation feature which meant that all information included in the website could be instantly available in over 100 languages.
- The practice population included a significant number of families in which family members spent university term times away from the home to register as temporary patients during holiday periods. People visiting or working locally for short periods could also be registered and seen in this way.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice was open between 8am and 6pm Monday to Friday. Telephones were answered between 8am and 6:30pm Monday to Friday. Appointments were from 9am to 1pm every morning and 2pm to 6pm daily. In addition to pre-bookable appointments that could be booked up to three weeks in advance, urgent appointments were also available for patients that needed them.

The practice was a member of The Kilburn Primary Care Co-op and patients could book appointment slots at a local hub until 9:00pm every weekday evening as well as between 9pm and 3pm on Saturdays and between 9am and 1pm on Sundays. These appointments were available with GPs and nurses, included childhood immunisations and cytology, and could be booked in advance.

Pre-bookable appointments with GPs and nurses could be booked up to three weeks in advance. The practice held a daily Duty Doctor session which offered a total of 21 slots every day, of which 12 were urgent appointments for people that needed them, six were open access for patients without appointments and three were dedicated to online e-consultations.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mixed in comparison to local and national averages.

- 54% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 72% and the national average of 76%.
- 60% of patients said they could get through easily to the practice by phone (CCG average 68%, national average 73%).
- 70% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment (CCG average 68%, national average 76%).
- 84% of patients said their last appointment was convenient (CCG average 87%, national average 92%).
- 60% of patients described their experience of making an appointment as good (CCG average 68%, national average 73%).
- 60% of patients said they don't normally have to wait too long to be seen (CCG average 40%, national average 58%).

We asked the practice to tell us what actions they had taken in response to the GP survey results. The practice told us they were aware that access to the service had become an issue during the previous twelve months. We were told that one GP partner had decided to relocate and had left the practice, whilst another GP partner was on long term sick leave. One of the practice nurses had also relocated and had left the practice. We saw minutes of meetings where staffing arrangements had been discussed and saw that a recruitment plan had been developed. This involved the recruitment of two salaried GPs, an advanced nurse practitioner and a physician associate. (Physician associates work under the direct supervision of a doctor and carry out many similar tasks, including patient examination, diagnosis and treatment). At the time of this inspection, the practice was able to demonstrate that the recruitment plan had been substantially delivered. The two new GPs had been recruited and were awaiting completion of pre-employment checks prior to commencing work. An advanced nurse practitioner had also been recruited and was due to commence employment shortly after the inspection. The practice had not yet recruited to the role of physician associate but had become a physician associate training practice.

The practice also told us that telephones were now answered between 8am and 6:30pm every day which was one hour longer than at the time of the previous inspection.

The practice also told us that they had brought about improvements in administrative functions and these were releasing clinicians from up to two hours of administration work each day. This had involved training practice service professionals in managing reading, coding, and actioning of incoming clinical correspondence safely and accurately. The practice had also recently agreed to participate in the NHS Workflow Optimisation scheme. (Workflow Optimisation was an approach to document management developed as part of the Prime Minister's GP Access Fund. It provides a framework which allows practices to redirect the flow of clinical administration work within the practice, releasing GPs to spend a greater proportion of their time with their patients. The training provided as part of the scheme means that clinical administration tasks are handled safely and accurately).

We also saw that the practice had recently received a Quality Premium award for achievements in prescribing,

Good

Are services responsive to people's needs?

(for example, to feedback?)

referrals and admissions. This award brought additional funding which was ring-fenced for spending in ways that improved quality of care or health outcomes and/or reduce health inequalities. The practice had identified access issues as one of the areas where this would be spent and showed us a business plan outlining how the additional funding would be spent. This involved improving face-to-face access for patients, implementing an electronic safety netting system to maximise engagement with hard-to reach groups such as mental health patients to have better primary care access, increasing GP capacity to consult with patients by reducing GP admin and improve bowel cancer screening uptake by investing in an improved patient recall system.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. For example, there was a poster about the complaints system in the waiting are and details were available on the practice website.
- The practice recorded all verbal complaints in addition to written complaints.

Complaints were reviewed at weekly management meetings and monthly partners meetings. We looked at complaints records for the previous five years and noted that the number of complaints had reduced from 110 in 2012/2013 to 60 in 2016/2017. We reviewed three complaints received in the last 12 months and found that these were handled in line with the practice complaint policy. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, we saw details of one complaint where the parent of a baby was given incorrect information about childhood immunisations. The practice had apologised to the patients and had ensured that they were provided with the correct information immediately. Staff had also been reminded of the importance of reviewing patient's immunisation history when booking appointments to avoid causing unnecessary distress to new parents.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. We saw plans which showed how the practice planned to realise its short, medium and long term objectives.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For instance, one GP had a lead role in overseeing mental health provision whilst another was responsible for all aspects of teaching and learning at the practice.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of three documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with consultant geriatricians, district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were recorded and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback by

Are services well-led?

Good

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

commissioning a monthly survey through the same organisation responsible for the carrying out the NHS Family and Friends test. The practice had also sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, we spoke with two members of the PPG who explained how they had helped the practice to understand how the previous queueing arrangements had compromised patient confidentiality and had helped to design a new system which had provided a reasonable distance between the queue and the reception desk.
- the NHS Friends and Family test, complaints and compliments received
- staff generally through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For instance, one GP partner had a special interest in cancer and the practice had taken a lead role trialling a new system to improve the coordination of cancer detection and treatment. The practice had also worked with the Institute of Psychiatry to improve lithium monitoring in general practice.

The practice had reviewed how work teams were structured in order improve cover arrangements during staff absence. Each GP had a dedicated administrative support team, known as Practice Support Professionals (PSPs). Historically, each GP and their team had a single 'buddy' GP who would provide cover when necessary. However, the practice had identified weaknesses in this system when a GP and their 'buddy' were away at the same time. The practice had responded to this by establishing two teams, each with a minimum of three doctors. This meant that there was always one doctor from both teams available and ensured that every patient was well known by more than doctor.

The GP with a special interest in mental health conditions had undertaken an advanced degree in Psychiatric Research and had published scholarly articles around Mental Health in the General Practice environment. They had also written or co-written articles about mental health for the medical press in this country and abroad and had been a contributor to national broadcast media in this field. This GP used this knowledge to support patients live healthier lives.