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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were generally well assessed although there were no records to show that all recommended actions contained in the annual infection control audit, fire risk assessment or risk assessment for legionella had been taken.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services was available and easy to understand.
- Information about how to complain was available on the practice website but was not displayed in the waiting area.
- Patients told us it was not always easy to make an appointment with a named GP although urgent appointments were usually available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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 and complied with the requirements of the Duty of Candour.

The areas where the provider should make improvements are:

- Ensure that notices advertising chaperone services are advertised clearly.
- Ensure that fire drills take place at regular intervals and that staff receive suitable fire awareness training.
- Ensure that Infection control audit records are updated when identified actions are completed.

Summary of findings

- Ensure that recommendations contained in the Legionella risk assessment are reviewed and records kept of actions taken.
- Ensure interpreting services are advertised clearly.
- Ensure information about the practice complaints process is advertised clearly.
- Consider reviewing the Quality and Outcomes Framework exception reporting process to provide additional assurance that patients with long term conditions are regularly reviewed

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Risks to patients who used services were assessed, but the systems and processes to address these risks were not always implemented well enough to ensure patients were kept safe.
- An infection control audit had been carried out in December 2015 but there were no records to demonstrate that recommended action points had been followed through.
- The most recent fire risk assessment had been carried out in November 2014. Although the practice could not provide records of regular fire drills, fire marshals had been appointed and staff we spoke to were able to describe an evacuation process. During our inspection, the practice had begun to develop a fire awareness programme and this included staff training and regular fire drills.

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 for the locality and compared to the national average.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

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 higher than others for several aspects of care.

Summary of findings

- 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 easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For instance, the practice was taking part in a CCG led pilot scheme involving the use of an online consulting system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect.

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 this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.
- There was an active patient participation group and GPs attended meetings of the group.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- A priority phone number was available for all patients 75 years old and over. Each month patients turning 75 years were sent a letter introducing them to the priority service.
- The practice used the local Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) to avoid unnecessary admission for elderly patients and to provide an enhanced level of home care during acute illness.

People with long term conditions

Requires improvement

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

- Data from QOF showed that the practice exception reporting rates for some long term condition indicators were significantly higher than local or national averages. For instance, the exception reporting rate for diabetes was 19% compared to the CCG average of 9% and a national average of 11%.
- GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Data from the Quality and Outcomes Framework (QOF) showed outcomes for patient with diabetes were better compared to practices nationally. For instance, 90% of patients had well controlled blood sugar levels compared to 78% nationally.
- The practice hosted regular 'Diabetes Educationand Self Management for Ongoing and Diagnosed'. (DESMOND) courses for patients with type 2 diabetes. (DESMOND is an NHS organisation that helps to deliver high quality patient centred education to people with type 2 diabetes, or those who are at risk of diabetes.)
- Longer appointments and home visits were available when needed.

Summary of findings

Families, children and young people

Good

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

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice had a comprehensive cervical screening programme. The practice's percentage of patients receiving the intervention according to 2014-2015 data was 82%, which was in line with the England average of 82%. Patients that had not attended for a screening appointment were followed up with letters and telephone calls.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Young people had access to information and could request chlamydia screening without an appointment. Practice staff understood issues around consent and demonstrated how they assessed whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- 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 had introduced 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 weekends between 9:00am and 3:00pm. These appointments were available with GPs and nurses, included childhood immunisations and cytology, and could be booked in advance.

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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding

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

- 91% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was above the national average of 84%.
- 96% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record in the preceding 12 months. (National average 88%).
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- One GP had a special interest in mental health care and was able to demonstrate how their research activities had contributed to reducing hospital admissions for some patients with mental health conditions.
- Patients experiencing poor mental health could be referred internally to the GP with a special interest in mental health care and other GPs could ask for a second opinion when that was helpful.
- Patients could benefit from internal expertise, including psychopharmacology and evidence-based mental health nutrition.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016. The results showed the practice was performing in line with national averages in some areas and was below national averages in other areas. There were 360 survey forms distributed and 126 were returned. This represented 1% of the practice's patient list.

- 84% found receptionists at this surgery helpful (national average 87%).
- 96% had confidence and trust in the last GP they saw or spoke to (national average 95%).
- 88% said the last nurse they saw or spoke to was good at listening to them (national average 91%).
- 72% were able to get an appointment to see or speak to someone the last time they tried (national average 76%).
- 78% described the overall experience of their GP surgery as fairly good or very good (national average 85%).
- 61% found it easy to get through to this surgery by phone compared to a national average of 73%.
- 68% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (national average 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards. All five had positive comments about a recent decision to open the surgery doors earlier in the mornings.

We spoke with eight patients during the inspection. All eight patients said they were happy with the care they received and thought staff were approachable, committed and caring. One patient said they had experienced difficulties 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 and a practice manager specialist adviser.

Background to The Lonsdale Medical Centre

Lonsdale Medical Centre provides GP primary care services to approximately 14,200 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 47 sessions per week. The practice is a training practice with three trainees in place at the time of our inspection. The trainees undertake approximately 18 sessions per week.

There are two practice nurses, one healthcare assistant, a practice manager, a phlebotomist (Phlebotomistsare specialist clinical support workers who take blood samples from patients) and ten administrative staff, one of whom has also trained as a phlebotomist. 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 9:00am and 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 out of hours services (OOH) are provided by LCW Cooperative. The details of the OOH service are communicated in a recorded message accessed by calling the practice when it is closed and details can also be found on the practice website. The practice provides a wide range of services including clinics for diabetes, phlebotomy, chronic obstructive pulmonary disease (COPD), contraception and child health care. The practice also provides health promotion services including a flu vaccination programme and cervical screening.

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%.

Detailed findings

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

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. The 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.

The practice had not been inspected under the previous inspection methodology.

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 23 February 2016. During our visit we:

- Spoke with a range of staff (four GPs, a trainee GP, practice manager, two nurses, reception manager and members of the administration and reception teams) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised 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.

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 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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place 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 practice carried out a thorough analysis of the significant events and these were discussed at weekly partners meetings.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, we looked at the significant events log and saw a case of a 'near miss' incident when a prescription for a controlled drug had gone missing between being printed and being collected by the patient. The practice had reviewed the incident and had taken action to prevent this happening again. All prescriptions for controlled drugs were now stored separately in a secure area and a note entered on the patient record indicating when the prescription was collected and by whom.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. We saw evidence of one occasion where the practice had undertaken a clinical review following the unexpected death of a patient and had ensured that the bereaved family had been made aware of the review and informed of the outcome.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and 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. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs and one practice nurse were trained to safeguarding level 3 and a second practice nurse was trained to safeguarding level 2.
- The practice told us that chaperones were available if required. There was no written chaperone policy and there were no notices about chaperones in the waiting area or in consulting rooms but we were told that clinicians told patients about the chaperoning service when appropriate. Records we saw indicated that all staff who acted as chaperones were trained for the role. All staff that carried out this roll had had a Disclosure and Barring Service check (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. A GP partner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. The most recent infection control audit had been undertaken in December 2015 but we noted that records had not been maintained when some recommended improvement actions had been completed.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- Prescription pads were securely stored, there were systems in place to monitor their use and serial numbers were logged in on receipt and out when taken by a GP or nurse. Patient Group Directions had been adopted by the practice to allow nurses to administer

medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Health care assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber
- We reviewed five personnel files and found that appropriate recruitment checks had been undertaken prior to employment. All files had records of appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

We looked at how risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives.
- The practice had last undertaken a fire risk assessment in November 2014 although there was no evidence to demonstrate that all recommended actions had been carried out. For instance, although fire alarms had been tested weekly, the practice was unable to show that regular fire drills had been carried out. We spoke to one member of staff who had been appointed as a fire marshal and they were able to describe their role and responsibilities, clearly and confidently. During our inspection, the practice had begun to develop a fire awareness programme and this included staff training and regular fire drills.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw a schedule of clinical equipment and evidence that calibration checks had been carried out in August 2015.
- The practice told us that following the departure of a previous member of staff, they had been unable to locate some current health and safety risk assessments. An external consultant had since been appointed to review and update these risk assessments. The consultant had attended the practice in December 2015 and a follow up meeting was scheduled for March 2016.
- We saw evidence that a risk assessment for legionella had been undertaken in March 2015 but the practice had not kept records to demonstrate that action points had been followed through. For instance, there was no written evidence that water storage tanks were being inspected and water temperatures checked. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- 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. There were records to show that these were checked regularly. 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 fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact details for staff as well as for utility companies and key services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place 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 peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice used a risk stratification tool to identify and support high risk services users.

One GP had a special interest in mental health care. This GP had expertise which included psychopharmacology and evidence-based mental health nutrition. Other GPs caring for patients experiencing poor mental health could ask for a second opinion or refer patients internally to the GP with the special interest when this was helpful. The practice was able to demonstrate how this had contributed to reducing medication levels and hospital admissions for some patients with mental health conditions.

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 recently published results showed the provider had achieved 99.9% of the total number of points available. This was similar to the clinical commissioning group (CCG) average of 93.5% and the national average of 94.8%. The practice had an exception reporting rate of 15.6% which was above the CCG average of 8.2% and the national average of 9.2%. 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.,

- Performance for diabetes related indicators was better than the national average. For example, 90% of patients with diabetes had well controlled blood sugar levels in the previous 12 months (national average 77%). The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 99% (national average 88%)
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 91% compared to the national average of 84%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 96% compared to the national average of 88%. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 91% (national average 84%).
- Patients with care plans on their records were recalled for an annual review during their birth months and this included patients with learning disabilities, long term conditions and older people.

We noted that exception reporting rates for a number of clinical domains were higher than CCG and national averages. For instance, the exception reporting rate for diabetes was 19% compared to the CCG average of 9% and a national average of 11%. The exception reporting rate for hypertension was 15% compared to the CCG average of 4% and a national average of 4%. We discussed these rates with the practice. We were told that GPs were responsible for exception reporting. GPs told us that patients were exception reported if they had not responded to the annual call recall system or were not clinically appropriate to be included in the QOF register. The practice explained that exception reported patients were still monitored during medication reviews, routine appointments and diarised annual reviews. The practice told us the exception reporting process would be reviewed prior to the next QOF year."

The practice hosted regular 'Diabetes Educationand Self Management for Ongoing and Diagnosed'. (DESMOND) courses for patients with type 2 diabetes. (DESMOND is an NHS organisation that helps to deliver high quality patient centred education to people with type 2 diabetes, or those who are at risk of diabetes.)

Clinical audits demonstrated quality improvement.

Good

Are services effective?

(for example, treatment is effective)

- There had been five clinical audits completed in the last two years. One of these was a completed audit of Accident and Emergency (A&E) attendance by the practice's patients. During the first cycle, the practice identified that 49% of A&E attendances were for illnesses which were self-limiting (conditions that resolve spontaneously with or without specific treatment.) The practice developed the website to promote information on self-managing certain self-limiting conditions. The second audit cycle demonstrated a 6.3% reduction in A&E attendance for self-limiting conditions.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action taken as a result included an update to the practice's prescribing guidelines for a certain urological condition and this update was presented to clinicians during a clinical meeting.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed clinical staff. It covered such topics as prescribing, patient referrals and basic guidance about the computer system. The practice had an induction system for non-clinical staff which involved new starters existing staff members to become familiar with procedures and policies.
- Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations 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 during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs.
- Staff received training that included: safeguarding, basic life support and basic confidentiality awareness. Staff had access to and made use of e-learning training modules and in-house training.
- Trainee doctors had weekly teaching sessions during protected time with their trainers as well as debriefing time after each clinical session.

Coordinating patient care and information sharing

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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. For instance, we saw how relevant patient notes and information was made available to out of hours services to ensure that patients received the care they needed during emergencies.
- The practice used an electronic process for patient referrals and had a secure procedure for checking that referrals had been received and appointments had been made.
- Pathology results were received electronically and all results were actioned daily. The practice operated a buddy system to ensure that all results were reviewed.

Staff worked together and with other health and social care services 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. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

The practice used the local Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) to avoid unnecessary admission for elderly patients and to provide an enhanced level of home care during acute illness

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

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.
- 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.
- We saw evidence that written consent was obtained for minor surgery. Signed forms were scanned into the computer system and attached to patient notes. Patient notes were also updated when verbal consent had been obtained, for instance when administering vaccines and immunisations.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 44% to 68% (CCG rates ranged from 44% to 68%) and five year olds from 50% to 90% (CCG rates ranged from 55% to 82%).
- There was information to signpost patients to support services for a variety of conditions and other needs. For instance we saw details of an organisation which provides support for younger people who are affected by alcohol and substance misuse by other people, an organisation which supports people affected by post-natal depression and a health checklist for children about to start at school.

The practice's uptake for the cervical screening programme was 73%, which was comparable to the CCG average of 68% and the national average of 74%. There was a policy to offer telephone 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice's uptake for bowel screening was 53% which was comparable to the CCG (47%) and national averages (58%). The uptake rate for breast screening cancer was 51% which was lower than the CCG average of 66% and the national average of 72%. We discussed these results with the practice who told us that the nearest screening centre was several miles away and this may have been contributing to the low uptake rate. The practice told us they had tried to negotiate with the team responsible for running the breast screening programme to have a scanning facility located at the practice but this had not been considered viable. The practice told us they had sent text message and email reminders to patients who were eligible.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Reception staff were careful not to repeat private information and sought to keep conversations private and this was important due to the acoustics and open plan nature of the reception area.
- Telephone calls were taken in separate area and could not be overheard.

All of the five patient Care Quality Commission comment cards we received contained something positive about the service experienced. Four patients said they appreciated the recently introduced earlier morning opening times for the surgery doors. Two patients expressed dissatisfaction with the process for making appointments.

We spoke with five members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 81% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 82% said the GP gave them enough time (CCG average 80%, national average 87%).
- 96% said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%)
- 80% said the last GP they spoke to was good at treating them with care and concern (national average 85%).
- 90% said the last nurse they spoke to was good at treating them with care and concern (national average 91%).
- 84% said they found the receptionists at the practice helpful (CCG average 83%, 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 on the comment cards we received was also positive and aligned with these views.

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:

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 70% said the last GP they saw was good at involving them in decisions about their care (national average 81%).
- 77% said the last nurse they saw was good at involving them in decisions about their care (national average 85%).

Staff told us that interpreting services were available for patients who did not have English as a first language. There was no information available in reception or the waiting area to inform patients of this.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. We saw that information was available about a range of condition symptoms and treatment, as well as information about support services for a range of needs including for mental health services. Examples of information available

Good

Are services caring?

included advice about drug and alcohol misuse, support for young people affected by other people's alcohol and drug misuse, post-natal depression and female genital mutilation.

Staff told us that patients who were homeless had been referred to a non-profit organisation that provided personalised support for people in vulnerable circumstances and this gave access to support in obtaining temporary and permanent housing solutions as well as providing psychological support during this difficult time

The practice's computer system alerted GPs if a patient was also a carer. The practice identified carers on an opportunistic basis had identified 2% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them and this included a very active local carer's network.

We saw details of the practice's bereavement protocol and staff told us that if families had suffered 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. This included referring family members to bereavement counselling when this was helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice was taking part in a CCG led pilot scheme involving the use of an online consulting system. This was a platform that enabled patients to self-manage and consult online with their own GP through the practice website. The practice's duty doctor had three slots per session reserved for these consultations.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these. Patients aged 75 years old and over were provided with a priority telephone number which bypassed the main switchboard. Each month patients turning 75 years were sent a letter introducing them to the priority service.
- Same day appointments were available for children and those with serious medical conditions.
- Appointments with the nurses were available outside of school hours and included slots of between 10 minutes and 30 minutes depending on the nature of the appointment.
- There were disabled facilities and a hearing loop available. The premises had automated doors and a lift which meant that all areas of the building were fully accessible.
- Interpreter services were available for patients who needed them, although there was no information displayed to let patients know this.
- The practice was situated close to a facility which supported people who had recently been released from prison. People using this facility could register as patients using the practice address as their postal address.
- The practice had recently installed 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 told us the health pod had been used for almost 4,000 consultations in the previous twelve months.

Access to the service

The practice was open between 8:00am and 6:30pm Monday to Friday. Telephones were answered between 9:00am and 6:30pm Monday to Friday. Appointments with GPs and nurses were from 9:00am to 1:00pm every morning and 2:00pm to 6:00pm daily.

The practice was a member of The Kilburn Primary Care Co-op and had dedicated appointment slots available at a local hub until 9:00pm every evening as well as at weekends between 9:00am and 3:00pm. 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 eight 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.

The practice told us they that it was standard procedure to ensure patients were seen and managed by their usual doctor wherever possible. This included home visits, non-urgent telephone calls and prescription reviews. GPs with special interests in particular conditions or with specific clinical skills were used as internal consultants rather than having patients transferred between GPs personal lists. The practice explained that this was to provide patients with continued holistic care, particularly older patients and those with long term conditions.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was worse than national averages.

- 60% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 61% patients said they could get through easily to the surgery by phone (national average 73%).
- 23% of patients said they always or almost always saw or spoke to the GP they prefer (national average 36%).

Good

Are services responsive to people's needs?

(for example, to feedback?)

We discussed these results with the practice. We were told that the practice had recognised that patients preferred longer opening hours, particularly in the mornings and had recently commenced a two month trial of opening the surgery at 8:00am. Whilst this only involved opening the doors earlier and did not include extending the times for appointments, telephone or reception access, patients we spoke with told us this was a very welcome change. This view aligned with feedback we received on patient comment cards.

The practice told us they were responding to pressure on the telephone system in a number of ways. They had updated the system to include an option to cancel appointments using a voice activated system meaning some patients no longer needed to speak to a receptionist. The practice told us they were actively promoting access to online services including repeat prescriptions, appointments, test results and messaging and this was reducing telephone waiting times.

At the time of our inspection, the next available urgent appointment was in one day, the next advance appointment available with any GP was within three days, whilst the next available appointment with one named GP was within 7 days. Most people we spoke with on the day of the inspection told us they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

We looked at the practice's system for handling complaints and concerns.

- Its complaints policy was 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.
- Information about the complaints procedure was not displayed in the waiting area but was available on the practice website and complaint forms could be accessed online or printed.

A practice spreadsheet indicated that the practice proactively recorded patient comments, feedback and complaints and a total of sixty two verbal and written entries had been recorded since April 2015. The practice could show how lessons had been learned from some complaints received, to improve the service but there was no consistent system for routinely analysing complaints trends and actions taken as a result to improve the quality of care. For example, one complaint referred to an occasion when reception staff had not prioritised a five year old patient for an urgent appointment. As a result of this complaint, the protocol for under five year olds presenting at the reception desk was reviewed and staff were reminded to ensure that younger children were always seen as a priority.

We reviewed three complaints and found they had been processed in line with practice policy and had received appropriate responses.

We were told that learning from complaints took place at staff team meetings but we noted that these meetings were not always minuted.

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 which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

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 in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The practice had a policy of rotating the role of Executive Partner every three years. This was part of the practice's succession planning policy and also served to ensure an even spread of senior management workload.
- Practice specific policies were implemented and were available to all staff
- An understanding of the performance of the practice was maintained
- Clinical and internal audit was used to monitor quality and to make improvements.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The practice had particular GP expertise in the fields of cancer and mental health. One of the practice GP's was a NHS England London wide lead for cancer care.

They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The practice was aware of the unique stresses under which GPs frequently work and had a policy under which every GP partner would take, during their career, a three month sabbatical break from work and were encouraged to pursue an interest unrelated to medicine.

The provider was aware of and complied with the requirements of the Duty of Candour and we saw an example of how this had been applied following the unexpected death of a patient. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

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

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

- The practice told us they operated a linear team management model. Each team was managed by a GP and included a nurse or other clinicians, and members of the reception and administration teams.
- 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 in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. 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, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly and submitted proposals for improvements to the practice management team. For example, the PPG had worked

Are services well-led?

Good

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

closely with practice management to reduce the number of appointments when patients did not attend (DNAs). This joint work had led to a reduction in DNAs from 350 to 200 per month.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. Nurses were supported in developing new clinical skills and one GP was currently undertaking an advanced degree in mental health. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area including online consulting and alternative access routes to counselling services.