The Stag Holyrood Surgery

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 Stag Holyrood Surgery on 13 July 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.
- The provider was aware of and complied with the requirements of the duty of candour.
- Risks to patients were assessed and well managed.
- 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 and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Most patients said they found it easy to make an appointment with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice was creative in its approach to removing the barriers to care faced by individual patients.
- There was a clear leadership structure and staff felt supported by the partners, the lead GP and management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

The practice had recently taken on a caretaking role for a nearby practice that had temporarily closed. However initially, the practice had been given no notice of the closure and was suddenly faced with patients from the closed practice arriving to consult with a doctor. The

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practice successfully set up a parallel reception, secured additional resources from its staff pool and started running the service the same day without cancelling patient appointments.

The areas where the provider should make improvement are:

- The practice should ensure its stock of emergency medicines is suitable to cover the needs of its patients, for example, including an injectable antibiotic.
- The practice should put in place a written protocol for its use of patient specific directions (PSDs) and use PSDs more consistently to govern the administration of vaccines by the health care assistants.
- The practice should increase the use of two-cycle audit to demonstrate that improvements to practice are well embedded and sustained.
- The practice should consider ways to improve patient uptake of the national bowel cancer screening programme.

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.

- There was an effective system in place 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 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 in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Data from the Quality and Outcomes Framework (QOF) showed the practice tended to be at or above average for most indicators.
- The practice population had a high prevalence of diabetes. The practice scored above average for its performance on managing diabetes.
- 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 other health care professionals 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 consistently rated the practice higher than others for many aspects of care.
- We saw staff treated patients with kindness and respect, and took care to protect patients' confidentiality.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were fully involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible at the practice.

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 NHS England and the clinical commissioning group to secure improvements to services where these were identified.
- Most patients said they could make an appointment when they needed one. Urgent appointments were 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 easy to understand and evidence 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 vision and strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity.
- There was an overarching governance framework which supported the delivery of good quality care. This included arrangements to monitor and improve quality and identify risk.
- The partners, the lead GP and practice managers encouraged an open culture. The practice complied with the duty of candour.
- The practice sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.

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.
- The practice provided the seasonal flu vaccination for patients over 65 and the shingles and pneumococcal vaccinations for eligible older patients.
- The practice had access to a local care coordinator who could visit older patients at home and could signpost patients to other services, clubs and events, for example, to reduce social isolation.
- The practice worked with local pharmacies to ensure prescription changes were actioned safely and in relation to the use of compliance aids where appropriate.

People with long term conditions

Good

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

- The practice kept registers of patients with long term conditions. These patients had a structured annual review to check their health and medicines needs were being met. The practice operated a call-recall system to encourage patients to attend for their review and attached a reminder to patients' prescriptions.
- The prevalence of diabetes was high locally. A specialist diabetes nurse attended the practice regularly to review newly diagnosed patients and patients with poor diabetic control.
- Practice performance for diabetes was above average. The percentage of diabetic patients whose blood sugar levels were adequately controlled was 84% compared to the national average of 78%.
- The practice participated in a local scheme to avoid unplanned admissions which included patients with multiple long term conditions. Patients identified as at risk were reviewed and had a personalised care plan. Cases were discussed at regular multidisciplinary meetings.

Summary of findings

Families, children and young people

Good

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

- There were systems in place 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 A&E attendances.
- Immunisation rates were higher than average for all standard childhood immunisations.
- Children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice offered antenatal check-ups lasting 15 minutes and the six-eight week postnatal checks which were booked to last 30 minutes.
- We saw positive examples of timely communication and referral to health visitors and other community health services.

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 and flexible.
- The practice was open until 6.30pm during the week. Nurse and GP appointments were available at these times. The practice offered daily telephone consultations with a GP and online appointment booking
- The practice offered a full range of health promotion and screening services reflecting the needs for this age group. The practice had identified a number of patients with previously undiagnosed diabetes through its programme of NHS health checks.
- 75% of eligible women registered with the practice had a recorded cervical smear result in the last five years compared to the CCG average of 77% and the national average of 81%.

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 people with a learning disability.
- The practice maintained a register of patients who were also carers.
- 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.
- 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.
- The practice shared with us several examples of how they had supported patients in difficult circumstances with positive outcomes.

People experiencing poor mental health (including people with dementia)

Good

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

- All patients with dementia had attended a face to face review of their care in the last year. We were told that the practice screened patients at risk of dementia and referred patients to a local memory clinic for further investigation and diagnostic tests.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice advised patients experiencing poor mental health how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

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 tended to score above the local and national average for patient experience. The survey programme distributed 349 questionnaires by post and 123 were returned. This represented 4% of the patient list (and a response rate of 35%).

- 82% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 68% and the national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 78% and the national average of 85%.
- 95% of patients said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 85%.
- 87% of patients described the overall experience ofthis GP practice as good compared to the CCG average of 80% and the national average of 85%.

We spoke with three patients during the inspection and received 27 completed patient comment cards. Patients were very positive about the practice, for example consistently describing the clinical staff as caring and the receptionists as helpful. Several patients gave us examples of personalised care or the compassionate support they had received at difficult times. Patients told us they were listened to and involved in decisions about prescriptions or other treatments. One patient told us they had made a complaint and this had been resolved promptly.

The practice had an active patient participation group and members told us the practice was responsive to suggestions and had made improvements as a result of patient feedback, for example, modernising the premises.

Areas for improvement

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The practice should ensure its stock of emergency medicines is suitable to cover the needs of its patients, for example, including an injectable antibiotic.
- The practice should put in place a written protocol for its use of patient specific directions (PSDs) and use PSDs more consistently to govern the administration of vaccines by the health care assistants.
- The practice should increase the use of two-cycle audit to demonstrate that improvements to practice are well embedded and sustained.
- The practice should consider ways to improve patient uptake of the national bowel cancer screening programme.

Outstanding practice

The practice had recently taken on a caretaking role for a nearby practice that had temporarily closed. However initially, the practice had been given no notice of the closure and was suddenly faced with patients from the closed practice arriving to consult with a doctor. The practice successfully set up a parallel reception, secured additional resources from its staff pool and started running the service the same day without cancelling patient appointments.

The Stag Holyrood Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector**.** The team included a GP specialist adviser.

Background to The Stag Holyrood Surgery

The Stag Holyrood Practice provides NHS primary medical services to around 3200 patients in Edgware, in the Brent Clinical Commissioning Group area. The service is provided through a general medical services contract.

The partnership owns another four practices in London. This inspection focused on the service provided at The Stag Holyrood Medical Centre.

The current practice clinical team comprises a lead GP with three associate GPs who work flexibly across the provider's practices. At the time of the inspection, the practice had an additional associate GP who focused on providing care to patients registered with a nearby practice which had temporarily closed. The practice employs a practice nurse and three health care assistants and a practice manager, administrative and reception staff. The GPs typically provide around 13 to 15 sessions in total each week. Most sessions are provided by female GPs but patients have the choice of seeing a male GP.

The practice team were in regular touch with the practice partners. One of the practice partners provided occasional clinical sessions at the practice for example, to cover leave. Another partner was the business manager for the provider group and visited the practice regularly.

The practice is open from 8am until 6.30pm during the week with the exception of Thursday when it closes for the afternoon from 1pm. Morning appointments are available from 9am to 12:30pm and afternoon appointments from 4pm until 6pm. Same day appointments are available for patients with complex or more urgent needs. The practice offers online appointment booking. The GPs make home visits to see patients who are housebound or are too ill to visit the practice.

When the practice is closed, patients are advised to use a contracted out-of-hours primary care service if they need urgent primary medical care. The practice provides information about its opening times and how to access urgent and out-of-hours services in the practice leaflet, on its website and on a recorded telephone message.

The practice population profile is similar to the national average although with a lower proportion of babies and young children. The population in the local area is characterised by average levels of income deprivation but higher than average unemployment rates. The practice population is ethnically diverse.

The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of diagnostic and screening procedures; maternity and midwifery services; surgical procedures; and treatment of disease, disorder and injury.

We previously inspected this practice on 29 April 2014. The practice was meeting all assessed standards at that time.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

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 13 July 2016. During our visit we:

- Spoke with a range of staff including the lead GP, a GP partner a sessional GP, the practice nurses, the practice manager, two health care assistants and a receptionist.
- Observed how patients were greeted on arrival at the practice.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.
- Interviewed three patients and met members of the patient participation group.
- Reviewed documentary evidence, for example practice policies and written protocols and guidelines, audits and monitoring checks.

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.

Good

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 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of significant events and an annual review. The practice shared learning with other relevant organisations when appropriate, for example, in relation to a poorly managed hospital discharge which had affected a practice patient.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice had reviewed its systems to manage urgent tasks following a significant event. As a result it had introduced designated slots in staff members' electronic diaries which were for the completion of any urgent tasks.

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 to safeguard children and vulnerable adults from abuse. These arrangements 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. One of the practice GPs was the safeguarding lead for the practice and the clinical commissioning group acting as a contact and source of advice to other practices in the area and attending local safeguarding board meetings. The GPs attended safeguarding case conferences when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and nurses were trained to child protection or child safeguarding level 3.
- Notices in the waiting and consultation rooms 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. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. 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. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient group directions (PGDs) 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). The health care assistants were trained to administer vaccines and medicines. The practice did not have a written protocol for its use of patient specific directions (PSDs) to govern vaccinations administered by health care

assistants. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).

- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had appropriate health and safety policies and protocols in place with named leads. The practice had up to date fire risk assessments and carried out periodic 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. The practice had risk assessments in place to monitor safety such as control of substances hazardous to health; infection control and legionella (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 needed to meet patients' needs. There was a rota system in place to ensure enough staff were on duty with the appropriate skill mix. The practice could also draw on the other practices in the provider group to help cover staff absence at short notice. At the time of the inspection, the practice had a part-time practice nurse vacancy. This had been covered by a locum nurse while the practice had recruited a permanent replacement.

Arrangements to deal with emergencies and major incidents

The practice had 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. 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 did not have an injectable antibiotic in its emergency stock and no risk assessment showing why this was unnecessary. Current guidelines recommend this medicine is stored for emergency use in primary care settings, for example, in case of suspected bacterial meningitis.
- 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 numbers for staff. The practice had recently put the plan into use following an electrical failure.

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 local 'pathways' agreed by the clinical commissioning group (CCG) and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that guidelines were followed through group discussion, audits, medicines reviews with individual patients and checks of patient records. The practice was able to show us multiple examples of audits against NICE guidelines, for example, recent audits of the management of patients with raised PSA (prostate-specific antigen) levels, and the prescribing of newer hypoglycaemic medicines for diabetes.
- Clinicians utilised standardised templates within the electronic patient record system for care planning and reviews of long term conditions which incorporated good practice guidelines.

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 for 2015/16 were 98.6% of the total number of points available compared to the national average of 98.6%. The practice tended to have lower exception reporting rates than average. (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).

Data from 2015/16 showed:

- The prevalence of diabetes was high locally. Thirteen per cent of the practice population had been diagnosed with diabetes. Practice performance for diabetes related indicators was above the local and national averages. For example, 84% of diabetic patients had blood sugar levels that were adequately controlled (that is, their most recent IFCC-HbA1c was 64 mmol/mol or less) compared to the CCG average of 76% and the national average of 78%. Eighty-four per cent of practice diabetic patients had a recent blood pressure reading in the normal range compared to the CCG average of 80% and the national average of 78%. The practice's exception reporting rates for diabetes indicators were lower than average.
- The practice provided a wide range of information for patients about diabetes. All newly diagnosed patients were referred to a structured education course about the condition and how to manage it. Patients we spoke with told us that they received helpful advice on managing their diabetes.
- In 2015/16, all patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, compared to the CCG average of of 86%.
- For patients with a diagnosis of psychosis, 96% had an agreed, comprehensive care plan compared to the CCG average of 91%.

There was evidence of quality improvement including clinical audit.

- The practice used clinical audit as a tool to monitor and improve its performance and had developed a standard template to record individual audit projects and the results. The practice had completed multiple clinical audits over the last two years, several of which were ongoing audits where improvements were monitored annually. Relatively few of the practice-initiated audits were completed two-stage audits where changes had been implemented and then reaudited to ensure improvement had been sustained. Topics included the prescribing of protein pump inhibitors, falls, and medication reviews. The latter had been prompted by a significant incident.
- Clinical audits were prompted by changes to guidelines, significant events and safety alerts. For example, the practice had taken on a caretaking role for a nearby practice which had temporarily closed. We noted that the practice had identified some concerns about certain aspects of care for these patients and had designed and carried out an audit. This resulted in changes to the clinical management of care for a number of patients in line with current guidelines.

Good

Are services effective?

(for example, treatment is effective)

- The practice participated in locality based audits, national benchmarking and peer review. The clinical staff also told us they were able to discuss and share findings with their colleagues across the provider group of practices which they found helpful, for example one of the doctors also had pharmacology expertise.
- Findings were used by the practice to improve services. For example an audit of anti-platelet therapy found that around a third of relevant patients needed a review of their treatment. The practice reviewed its prescribing protocols which were discussed with the clinicians. The lead GP planned to repeat the audit to ensure that changes to practice had been embedded.

Effective staffing

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

- The practice had a structured 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.
- 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 on going support, one-to-one meetings, team meetings and informal discussion and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- We were told that reflection, learning and development was encouraged. For example, the partners organised a weekly clinical teleconference covering all five practices in the provider group and including locum GPs. However, we were also told that protected time for training and development had been constrained in recent months due to the practice taking on a caretaking role for another practice and the associated increase in patient demand.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance.

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.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

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.

The practice participated in the local integrated care programme aiming to avoid unnecessary hospital admissions for patients assessed to be at high risk. Practice clinicians attended multidisciplinary meetings in the locality at which care plans were routinely reviewed and updated for patients with complex needs. The practice also routinely liaised with health visitors, district nurses and the local palliative care team to coordinate care and share information.

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.
- 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 assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services effective?

(for example, treatment is effective)

The practice had systems in place to ensure that where patients had made advance decisions, these were communicated to other services when necessary, for example, to the ambulance service if attending out of hours.

Supporting patients to live healthier lives

The practice identified patients in need of extra support. 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.

In 2015/16, the practice uptake for the cervical screening programme was 75%, which was comparable to the CCG average of 77% and the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice ensured a female sample taker was available. There were failsafe systems in place 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 screening. In 2014/15, the uptake for breast cancer screening was 68% which was in line with the CCG average of 66%. Bowel cancer screening uptake however was below average at 31% compared to the CCG average of 43%.

Childhood immunisation rates were in line with the local average. For example at the time of the inspection, 82% of eligible babies had received the 'five in one' vaccination by the age of two years. For the preschool cohort, 74% had received their pre-school boosters.

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. The staff carrying out health checks were clear about risk factors requiring further follow-up by a GP. The practice had identified a number of patients with undiagnosed diabetes as a result of carrying out these routine checks.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were polite and helpful to patients and treated them with 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 were able to take patients to a more private area if they needed to discuss sensitive issues or appeared distressed.

Patients who participated in the inspection were very positive about the practice, for example consistently describing the clinical staff as caring and the receptionists as helpful. Several patients gave us examples of personalised care or the compassionate support they had received at difficult times.

Results from the national GP patient survey reflected these findings. The practice tended to score above the local and national averages for patient experience of consultations, particularly with a GP. For example:

- 92% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 85%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 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. Patients gave us examples of being involved in decisions, for example about long term prescriptions and on managing health conditions. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision. We saw that care plans were personalised.

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. Again, the practice results tended to be above the local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 82%.
- 78% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 85%.

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

- The staff team spoke a range of languages including Gujarati, Hindi, Romanian, Spanish and Polish. Translation services were also available for patients who did not have English as a first language.

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. Some patients told us they had received compassionate support from their GP during difficult times or situations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 57 patients who were carers (2% of the practice list) and 21 patients who

Good

Are services caring?

had a carer (not necessarily registered at the practice). The practice had also explicitly identified young carers. The practice offered carers flu vaccination and priority for appointments. Written information was available to direct carers and young carers to the various avenues of support available to them, for example a local scheme offering respite support and the local carers centre.

Staff told us that if patients had suffered bereavement, the GP would visit or telephone and the practice sent a condolence card. The practice signposted patients to bereavement support services and recorded the bereavement in their medical records to ensure the clinical team would be aware.

The practice had a register of patients receiving palliative care. The lead GP had talked with these patients about their plans for the end of life, for example, their preferred place of death and liaised with other services to meet their wishes. The lead GP was able to tell us how many patients had recently died in their preferred place although this information was not formally recorded in the patients' medical records.

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, the clinical commissioning group (CCG) and its locality group of GP practices to secure improvements to services where these were identified.

- The practice offered a range of diagnostic tests at the surgery for the convenience of patients including blood tests, spirometry testing, electrocardiogram monitoring and 24 hour blood pressure monitoring.
- There were longer appointments available for patients with a learning disability or other more complex needs.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and patients with urgent medical problems.
- The practice offered travel vaccinations. The practice provided information about which vaccinations were available free on the NHS and which were available at alternative centres.
- There were disabled facilities, a hearing loop and translation services.
- The practice was able to provide examples showing how it responded to individual needs and looked for creative ways to overcome barriers to care. For example in one case, the practice staff had been trained on how to provide a specific treatment (normally provided in acute settings) enabling them to provide this to a patient with complex needs at the surgery. In another example, the lead GP had worked with a patient with a chaotic lifestyle to engage with primary and dental care services. In both cases, the patients' health and wellbeing had greatly improved.

Access to the service

The practice was open from 8am until 6.30pm during the week with the exception of Thursday when it closed for the afternoon from 1pm. Morning appointments were available from 9am to 12:30pm and afternoon appointments from 4pm until 6pm. Same day appointments were available for patients with complex or more urgent needs. The practice offered online appointment booking. The GPs made home visits to see patients who were housebound or too ill to visit the practice.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment tended to be above the local and national averages.

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and the national average of 76%.
- 82% of patients said they could get through easily to the practice by phone compared to the CCG average of 68% and the national average of 73%.
- 78% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 78% and the national average of 85%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. Patients were able to request appointments with a male or female GP. Routine appointments with most named GPs were available within two weeks depending on the number of sessions they worked.

Some patients said the recent increase in patients using the practice had adversely affected access, notably the ease of getting through to the practice by telephone. However, patients said they had been informed about the situation and understood why the situation had arisen. Some patients also told us they had difficulty obtaining an urgent appointment outside of working hours. The practice was able to refer patients to local primary care 'hub' services which were open in the evening and at weekends to patients resident in Brent.

The practice had a system in place 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 an effective system in place for handling complaints and concerns.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 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. One of the patients we spoke with said they had previously made a complaint and this had been resolved promptly and to their satisfaction.

We looked at five written and three verbal complaints received in the last 12 months. Lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care. The practice included verbal complaints and complaints posted on the NHS internet feedback site for consideration.

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 area and staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and they 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.
- Practice specific policies were implemented and were available to all staff in folders and on the shared drive.
- There was a comprehensive understanding of the performance of the practice. Benchmarking information was used to monitor practice performance in comparison to other practices within the same locality.
- There were arrangements for identifying, recording and managing risks and implementing mitigating actions.
- The administrative staff prepared and emailed a daily report of relevant activities to the head office.

Leadership and culture

The partners and senior staff in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised holistic and patient centred care and were able to provide examples and case studies. The partners and lead GP were accessible. the partners were available by telephone when not present at the practice.

- There was evidence that changes to policies, guidelines, systems and processes were shared with staff. For example, staff members had signed updated policies to indicate they had read and were aware of the current version.
- Staff said they felt respected, valued and supported by the partners, the lead GP and the practice managers.
- The practice held regular staff meetings and weekly clinical teleconferences across the five practices owned by the partners. Records were kept for future reference. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issue.
- The practice complied 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).

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

The practice encouraged and valued feedback from patients, the public and staff. It sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team.
- The practice had also gathered feedback from staff through appraisals and staff discussion.
- 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 focus on learning and improvement at all levels within the practice. The practice sought feedback from staff and patients, which it acted on. The patient participation group was active. The practice acted on updates, incidents and alerts and investigated issues further, for example through audit if required.
- Staff told us the practice was keen to implement suggestions for improvement, for example, one of the receptionists had put together a short guide to booking the right length appointment depending on the nature of the appointment.