

# St Peter's Street Medical Practice

## Quality Report

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Date of inspection visit: 14 July 2016  
Date of publication: This is auto-populated when the report is published

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

## Ratings

Overall rating for this service	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 14 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.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with 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 how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

- 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.
- Patients said they sometimes encountered delays when making appointments. However, the practice operated a walk-in clinic each weekday morning for which no appointment was needed.

There were some areas where the practice should make improvements:

- The practice should consider making more information available to patients clarifying how the walk-in clinics operate and the availability of telephone consultations.
- It should continue to review its staffing levels particularly relating to the nursing team.
- It should consider arranging for clinical staff to regularly attend meetings with the patient participation group.

# Summary of findings

**Professor Steve Field CBE FRCP FFPH FRCGP**

Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as 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.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were above local and national averages.
- The practice monitored performance and where the need for some improvement had been identified it had implemented actions.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice was seeking to appoint more salaried nurses to reduce the workload of GPs.
- 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.

Good



### Are services caring?

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.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Good



# Summary of findings

- 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?

The practice is rated as good for providing responsive services.

- Patients said they sometimes encountered delays when making appointments. However, the practice operated a walk-in clinic each weekday morning for which no appointment was needed. The walk-in clinics had been introduced, following patient feedback on access to the service.
- Evening appointments were available for patients unable to attend during normal working hours.
- Patients told us the practice was accessible, flexible and offered continuity of care.
- 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.

Good



## Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had 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 notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.

Good



# Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. It had requested that more clinical staff attend meetings and the practice had agreed to this.
- 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

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 maintained a case management register of patients at high risk of admission to hospital. Eighty-six patients aged over 75 years were recorded on the register, all of whom had up to date care plans.
- Records showed that 13 patients aged over 65 years were prescribed four or more medications; 10 (77%) of whom had had a medication review in the last 12 months.
- Patients aged over-75 could book slots in the daily walk-in clinics by telephone.
- The uptake for bowel cancer screening was above the local average.

Good



### People with long term conditions

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

- The practice held monthly meetings to discuss patients at higher risk of unplanned admission to hospital.
- Longer appointments and home visits were available when needed.
- All 1,527 patients with recorded long-term health conditions had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice maintained a register of 309 patients with diabetes, of whom 278 were eligible for a foot examination and risk assessment. Data showed that 263 patients (95%) had undergone a foot examination.
- The practice's performance relating to diabetes care was above local and national averages.
- The practice maintained a register of 43 patients with heart failure, of whom 30 had had an annual medicines review in the preceding 12 months.

Good



# Summary of findings

- The practice's performance relating to asthma care and chronic obstructive pulmonary disease was comparable with local and national averages.

## Families, children and young people

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 and maintained a register of vulnerable children.
- Take up rates for all standard childhood immunisations were above the local average.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors, including monthly MDT meetings and a monthly clinic with the health visitor.
- The practice had introduced chlamydia self-testing to improve detection and treatment following an in-house audit.

Good



## Working age people (including those recently retired and students)

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

- 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.
- Evening appointments were available for those patients who could not attend during normal working hours.
- Telephone consultations were available, but some patients were not aware of this.
- The practice's uptake for the cervical screening programme was 84%, being above the local and national averages.
- Data showed that 5,312 patients (62% of those eligible) had undergone blood pressure checks in the last five years.

Good



## People whose circumstances may make them vulnerable

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

Good



# Summary of findings

- The practice held a register of patients living in vulnerable circumstances including travellers (two patients) homeless people (11), and those with a learning disability (21).
- The practice offered longer appointments for patients with a learning disability. Patients on the learning disability register had been sent three invitations for an annual health check in the last 12 months; 14 of whom had attended for the check. All patients on the register had a named GP.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- 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)

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

- The practice maintained a dementia register of 31 patients. Data showed that 27 patients (90%) had had their care reviewed in a face-to-face review in the preceding 12 months, being above both local and national averages.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- Continuity of care for patients experiencing poor mental health was prioritised.
- The practice had a register of 90 patients with severe mental health problems, 95% of whom had an agreed care plan documented in their records, being above both local and national averages.
- The practice had told patients experiencing poor mental health about 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.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



# Summary of findings

## What people who use the service say

The latest national GP patient survey results available at the date of the inspection had been published in January 2016 and covered the periods January - March 2015 and July - September 2015. The results showed the practice was performing in line with local and national averages. Three hundred and sixty four survey forms were distributed and 114 were returned. This represented roughly 1.1% of the practice's list of approximately 10,700 patients.

- 90% of patients found it easy to get through to this practice by phone compared to the local average of 76% and the national average of 73%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 83% and the national average of 85%.
- 92% of patients described the overall experience of this GP practice as good compared to the local average of 81% and the national average of 85%.
- 82% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 76% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 40 comment cards, most of which were very positive about the standard of care received, saying that staff were friendly, supportive and helpful, and that the premises were always clean. They said that GPs and clinical team took time to explain healthcare issues and involved them in decision making. Seven of the cards mentioned difficulties in making appointments.

We spoke with 10 patients during the inspection, together with three members of the patient participation group. The patients said they were generally very satisfied with the care they received and thought staff were approachable, committed and caring. Most of the patients we spoke with had attended the walk-in surgery that was operating, preferring it to booking an appointment, which some told us often involved delay.

The latest available Friends and Family Test results showed that of four out of six patients who had responded (67%) were likely to recommend the practice.

## Areas for improvement

### Action the service SHOULD take to improve

- The practice should consider making more information available to patients clarifying how the walk-in clinics operate and the availability of telephone consultations.
- It should continue to review its staffing levels particularly relating to the nursing team.
- It should consider arranging for clinical staff to regularly attend meetings with the patient participation group.

# St Peter's Street Medical Practice

## 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, a practice nurse specialist adviser and an Expert by Experience.

## Background to St Peter's Street Medical Practice

St Peter's Street Medical Practice operates from 16 and a Half St Peter's Street, London, N1 8JG, converted domestic premises, owned by the practice. It is close to Islington Angel and has good transport links nearby.

The practice provides NHS services through a General Medical Services (GMS) contract to approximately 10,700 patients. It is part of the NHS Islington Clinical Commissioning Group (CCG) which is made up of 38 general practices. The practice is registered with the CQC to carry out the regulated activities Treatment of disease, disorder or injury, Family planning. The patient profile for the practice has a higher than average working age population, with a lower than average number of teenagers and patients aged over-50.

The practice has a clinical team of six partner GPs (four female and two male) and a salaried female GP. Two of the partners work part time; the other GPs work full time. The GPs worked between five and seven clinical sessions per week. It is a training practice, with one female registrar (a qualified doctor gaining general practice experience) currently placed there. There is a practice nurse manager,

who was on maternity leave at the time of our inspection, and a female health care assistant, who works part time. Locum nurses are being used to cover. There is a practice manager and deputy and an administrative and reception team of eleven staff.

The practice's opening hours are 8.30 am to 6.30 pm, Monday, Tuesday and Friday; 8.30 am to 2.45 pm on Wednesday; and 8.30 am to 8.45 pm on Thursday. Appointments can be booked for consultations between 8.30 am to 10.00 am each morning; from 3.00 pm until 6.30 pm on Monday, Tuesday and Friday; from 1.30 pm to 2.45 pm on Wednesday; and from 3.00 pm until 8.45 pm on Thursday. Morning and afternoon appointments may be booked up to four weeks in advance. Appointments for Thursday evening can be booked up to one week in advance. In addition, the practice operates a walk-in service each morning from 10.00 am. Patients wishing to use the walk-in clinic are required to attend the practice between 8.30 am and 10.00 am, to add their name to the clinic list and they are to be given an estimated time slot. Patients aged over-75 can register for the walk-in clinic by phone. GPs cover the walk-in service by pre-arranged rota. The GPs conduct telephone consultations with patients and make home visits.

The practice is closed at weekends, but a number of weekend appointments are available under a local scheme operating from three locations in the borough. The practice has opted out of providing an out-of-hours service. Patients calling the practice when it is closed are connected with the local out-of-hours service provider. There is information given about the out-of-hours provider and the NHS 111 service on the practice website.

# Detailed findings

Routine appointments with preferred GPs can be booked up to four weeks in advance. Pre-booked appointments are 10 minutes long, but patients may book double appointments if there are a number of healthcare issues to discuss, or if interpreting services are required. Walk-in consultations are not limited to 10 minutes. Appointments with nurses are 15 minutes long. Patients can book appointments online if they have previously registered to use the system. Patients who have provided the practice with their mobile telephone numbers are sent text reminders of their appointments.

## Why we carried out this inspection

We carried out a comprehensive inspection of the practice 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 previously.

## 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 14 July 2016. During our visit we:

- Spoke with a range of staff including partner GPs and a salaried GP, a locum nurse, the practice manager and deputy and members of the administrative team. We also spoke with 10 patients who used the service and three members of the patient participation group.

- 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.

Following the visit, our practice nurse specialist adviser spoke with the practice nurse manager by phone. The practice nurse manager was currently away from the service on maternity leave.

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.

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events. These included actual incidents and near misses.

- The practice manager had responsibility for leading on significant events and incidents. 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 had a detailed procedure for recording and investigating significant events, to ensure a thorough analysis of the significant events was carried out. We saw that events were discussed at monthly meetings and all staff were encouraged to contribute to discussions. In addition, we saw that significant events were reviewed annually to identify trends and review performance.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw that the clinical team received safety alerts individually and the alerts were collated and filed by the administrative team. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, there had been 19 incidents treated as significant events in the previous 12 months. Eight had related to clinical issues, the remainder were administrative matters. We saw that there had been two incidents relating to how prescriptions had been processed by members of the administrative team which resulted in staff being given further training and guidance. We noted

that another incident, involving a duplicate immunisation being given to a child by a locum nurse had been shared with NHS England. The locum concerned was no longer used by the practice.

### 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. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and had last been reviewed in April 2016. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The lead partner GPs was responsible for both adult safeguarding and child protection issues. Safeguarding was a standing item on the monthly full team meeting agenda. Cases of concern were systematically coded and updated. The practice ran monthly records searches to monitor cases. There were monthly meetings with health visitors to discuss new and ongoing concerns and we saw minutes to confirm this. 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 on safeguarding children and vulnerable adults relevant to their role. GPs and the practice nurse manager were trained to child safeguarding level 3, with the other staff being trained to level 1.
- A notice in the waiting room advised patients that chaperones were available if required. Staff who performed chaperone duties had received formal training and repeat Disclosure and Barring Service (DBS) checks had been carried out. A male member of staff was due to be trained shortly. 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. Cleaning was undertaken by a contractor following agreed written cleaning schedules. Monthly review meetings with the contractor were held and there was a communications book allowing

## Are services safe?

comments and messages to be passed to the cleaners. Practice staff carried out walk around inspections every fortnight to identify any concerns relating to cleaning and general health and safety. Any issues were raised with the cleaning contractor using a communications book. One of the partner GPs worked with the practice nurse manager to lead on infection control issues. The infection control policy had last been reviewed and updated in November 2015. The practice 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 online training. Annual infection control audits were carried out, but one was overdue. We were sent evidence that an audit had been carried out a few days after our inspection. The few minor issues identified had an appropriate timescale to put right. All but one piece of equipment we inspected was in date and fit for use. The item in question was removed by a staff member when we brought their attention to it. We found one sharps bin that was overdue removal. Clinical waste was stored in a secure area, not accessible by patients, and was collected weekly and disposed of by a licensed contractor. Notices advising on procedures relating to sharps injuries were posted in the treatment and consultation rooms. Curtains in the treatment and consultation rooms had a note affixed of when they had been put up and were due to be cleaned or changed. Curtains in the nurse's room were disposable. The practice had spillage kits and a sufficient supply of personal protective equipment, such as surgical gloves, aprons and masks. All medical instruments were single-use. Staff we spoke with were aware of the appropriate procedures to follow.

- 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 the nurses to administer medicines in line with legislation. However,

we found there were none in place for the locum nurse working on the day of the inspection. We discussed this with the practice which immediately contacted the locum agency to clarify the issue. It was agreed that in future all locum nurses would bring a supply of forms for completion by practice GPs on the day. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. The practice appropriately monitored and recorded stocks of medicines and vaccines. The practice's vaccines fridges had been inspected in October 2015. We saw that the vaccines fridge temperature was also monitored and recorded. All the medicines and vaccines we saw were within date and fit for use.

- We reviewed five 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 Criminal Records Bureau or later by 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. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. A fire risk assessment had been carried out in February 2016, when firefighting equipment had been checked and serviced. All staff had undertaken annual fire awareness e-learning and a number were to be trained as fire wardens. The practice carried out regular fire drills. The annual testing of electrical equipment (PAT testing) had been carried out in December 2015. The annual inspection and calibration of medical equipment had been done in December 2015. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella, a particular bacterium which can contaminate water systems in buildings. This included carrying out regular premises health and safety checks. The practice confirmed shortly after our visit that an asbestos inspection of the premises had been carried out

## Are services safe?

### 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.
- The practice had a defibrillator available on the premises, which was checked on a regular basis. We saw

that the pads were in date and the battery was charged ready for use. The practice had an emergency oxygen supply, a first aid kit and an accident recording book was used.

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan in place, which had been reviewed and updated recently following a power failure. It included arrangements for the service to be provided from alternative nearby premises. The plan contained emergency contact numbers for staff.

# 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 patients' needs. One of the partner GPs co-ordinated the process for dealing with NICE guidelines received. The duty GP received any daily alerts and distributed them to colleagues. Guidelines and alerts were collated in an alerts folder and passed on to clinicians by email. They were also discussed at practice meetings. Staff told us of recent examples of guidelines relating to cancer care and coeliac disease. We saw minutes of a clinical meeting when NICE guidelines regarding bladder cancer had been reviewed and another when a health alert from NHS England on an increase in measles cases in London had been discussed.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recently published results related to 2014/15 and were 99.9% of the total number of points available being 6.2% above the CCG average and 5.2% above to the national average. The practice's clinical exception rate was 9.9%, which was 0.2% below the CCG average and 0.7% above the national 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.

This practice was not an outlier for any QOF or other national clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was 100%, being 12.2% above the CCG average and 10.8% above the national average.
- Performance for hypertension related indicators was 100%, being 3.3% above the CCG average and 2.2% above the national average.
- Performance for mental health related indicators was 99.96%, being 7.5% above the CCG Average, and 7.2% above the national average.

The practice provided us with data for 2015/16, which showed similar figures were attained, with an overall score 98% (548.57 points from the maximum available 559 points).

There was evidence of quality improvement including clinical audit. These included ones that had been initiated by the practice as well as a number by the local CCG. There had been 28 clinical audits carried out in the last two years. Of these, six were completed or ongoing repeat audits where the improvements made could be and monitored. An audit of patients who were prescribed methotrexate, a drug used to treat certain types of cancer, was conducted over three years from 2014. The number of patients who had not been given a National Patient Safety Agency patient information leaflet was found to have decreased over the course of the audits. The six patients who had not been given the leaflets in the final round of the audit had either started their treatment in secondary care or were new to the practice. The practice was able to provide them with the leaflets. The practice was also been able to use the audit findings to identify which of these at risk patients had not been given a flu vaccine and to introduce steps to increase the provision of the vaccine. This would be done by a message promoting flu vaccinations to accompany all methotrexate prescriptions issued between September 2016 and January 2017.

### Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice nurse manager was on maternity leave at the time of the inspection. When on duty, the practice nurse manager spent two days a month at the practice, otherwise working remotely with access to the records systems and speaking with patients by phone on matters such as health promotion. The practice had sought to recruit nurses, but found it difficult and was using locums. As a consequence, the GPs had an additional workload, dealing with matters that employed

# Are services effective?

## (for example, treatment is effective)

nurses would normally be able to cover. Two salaried GPs had recently been appointed to assist in workload; one was already working and the other was due to commence shortly.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- We saw examples of planned work rotas for both clinical and administrative staff.
- The practice had a suitable information pack for use by locum GPs employed from time to time.
- 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 ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support the Mental Capacity Act and information governance. Staff had access to and made use of a range of e-learning training modules and in-house training.

### 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. Care plans for patients with complex needs were routinely reviewed and updated. Multidisciplinary team meetings (MDTs) took place with other health care professionals on a monthly basis. There were separate MDTs relating to palliative care, child protection, district nurse and community matron, and avoiding unplanned admissions to hospital.

### 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. The practice computer system contained appropriate templates for use in establishing patients' mental capacity to consent and to record action taken in the patients' best interest.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to the relevant service. 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. The practice had identified 1,641 patients aged over-16 who were smokers and had offered advice and support to 1,250 (76%) of them; 31 patients had given up smoking in the last 12 months.

## Are services effective? (for example, treatment is effective)

The practice's uptake for the cervical screening programme 84% which was above the CCG average. 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. For example, personalised bowel cancer screening invitations were sent on patients' sixtieth birthdays. 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.

Childhood immunisation rates were above local averages. For example, rates for the vaccinations given to under two year olds ranged from 96% to 100% and for five year olds from 92% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 35-74 years. Data showed that 5,312 patients (being 62% of those eligible) had undergone blood pressure checks in the last five years. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# 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.
- Telephone calls were handled in a room away from the reception area, where they might be overheard.

Almost all the 40 patient comments cards we received and the 13 patients we spoke with were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards and patients we spoke with highlighted that staff responded compassionately when they needed help and provided support when required.

The practice's satisfaction scores on consultations with GPs and nurses were generally above local averages. For example -

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 83% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern, compared to the CCG average of 83% and the national average of 85%.
- 96% 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%.

In addition, 93% of patients said they found the receptionists at the practice helpful (CCG 86% and national 87%).

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey regarding patients' involvement in planning and making decisions about their care and treatment were comparable to local and national averages. For example -

- 87% 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%.
- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 91% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 77% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice was praised in a report by the local Healthwatch team regarding interpreters being offered to assist patients registering.

### 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.

## Are services caring?

The practice's computer system alerted GPs when a patient was recorded as being a carer. The practice had identified 250 patients as carers, being approximately 2.3% of the practice list. Written information was available to direct carers to the various avenues of support available to them.

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. We saw information about bereavement services was available in the waiting area.

# 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.

- Routine pre-booked appointments were available from 8.30 am Monday to Friday and until 8.45 pm on Thursday evening for patients not able to attend during normal working hours.
- Routine appointments could be booked up to four weeks in advance.
- Emergency consultations were available for children and those patients with medical problems which required urgent consultation.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- All patients could request a telephone consultation, avoiding the need to attend the practice.
- There were disabled facilities, translation services and a hearing loop available.
- Appointments could be booked, and repeat prescription requested, online.
- Text reminders, regarding appointments and regular routine monitoring, were sent to patients who had provided their mobile phone numbers.

### Access to the service

The practice's opening hours were 8.30 am to 6.30 pm, Monday, Tuesday and Friday; 8.30 am to 2.45 pm on Wednesday; and 8.30 am to 8.45 pm on Thursday.

Appointments could be booked for consultations between 8.30 am to 10.00 am each morning; from 3.00 pm until 6.30 pm on Monday, Tuesday and Friday; from 1.30 pm to 2.45 pm on Wednesday; and from 3.00 pm until 8.45 pm on Thursday. Morning and afternoon appointments could be booked up to four weeks in advance. Appointments for Thursday evening could be booked up to one week in advance. In addition, the practice operated a walk-in service each morning, commencing at 10.00 am. Patients wishing to use the walk-in clinic were required to attend the practice between 8.30 am and 10.00 am, to add their

name to the clinic list and they would be given an estimated time slot. Patients aged over-75 could register for the walk-in clinic by phone. GPs covered the walk-in service by pre-arranged rota. The GPs conduct telephone consultations with patients and make home visits.

Pre-booked appointments were 10 minutes long, but patients could book double appointments if there are a number of healthcare issues to discuss, or if interpreting services were required. Walk in consultations were not limited to 10 minutes. Nurses' appointments were 15 minutes long. Patients can book appointments online if they had previously registered to use the system. Patients who have provided the practice with their mobile telephone numbers are sent text reminders of their appointments.

The practice closed at weekends, but a number of weekend appointments were available under a local scheme operating from three locations in the borough. The practice had opted out of providing an out-of-hours service. Patients calling the practice when it is closed were connected with the local out-of-hours service provider. There was information given about the out-of-hours provider and the NHS 111 service on the practice website.

The premises were accessible to patients with mobility problems. There were nine treatment / consultation rooms, with two each in the basement and first floor, and five on the ground floor. Two of the ground floor rooms had step-free access; the other three were up three steps.

We saw from the results of the national GP patient survey showed that 90% of patients said they could get through easily compared to the local average of 76% and the national average of 73%. We also noted that 64% of patients were satisfied with the practice's opening hours compared to the local average of 68% and the national average of 75%. None of the patients we spoke with, or any of the comments cards we received, referred to opening hours being a problem. However, several cards and patients mentioned long waits in getting appointments. This was offset by the walk-in service that operated each morning. The service had been introduced four years ago, following patient feedback and discussion with the patient participation group. Patients wishing to use the walk-in service needed to attend between 8.30 am and 10.00 am to

# Are services responsive to people's needs?

(for example, to feedback?)

be given an estimated time for being seen. Patients aged over-75 could phone the practice for a slot, but a younger patient told us attending in person was difficult for them as they had small children to look after.

A number of patients we spoke with were confused about how the walk-in service was run. We discussed this with the practice and staff agreed to clarify the process both on the practice website and the relevant page of NHS Choices. A comment card mentioned that telephone consultations would be preferred, indicating that the option, which was already available, was not sufficiently-well advertised.

## Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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. There were notices posted around the premises and a complaints leaflet available both at the practice and on its website.

We saw that 20 complaints had been made during the last 12 months. The complaints were satisfactorily handled, dealt with in a timely way, with openness and transparency. They were monitored and discussed at monthly meetings and reviewed on an annual basis, most recently in March 2016. Monitoring information regarding complaints was also shared with the patient participation group. The complaints were analysed to identify any trends and action was taken to as a result to improve the quality of care. For example, a patient submitted a complaint regarding a drug they had been prescribed to assist them sleeping. From their own research, the patient had found that the drug was also used as an anti-depressant and had been concerned with this. The practice responded by clarifying that the drug had different uses, depending on the dosage prescribed. The issue was discussed within the practice and it was resolved that in future prescribers would be mindful of individual patients' concerns and would explain the different uses drugs may have.

# 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's mission statement was displayed at the premises and set out on the website -

"In a safe and comfortable environment, we aim to provide the highest standard of care to ALL of our patients. We promise to treat our patients with dignity and respect, and offer them the best level of healthcare that we can."

It had a robust strategy and supporting business plans which reflected the aims and values and which 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. Policy reviews were diarised and revised documents were sent to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

The partner GPs demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partner GPs were approachable and always took the time to listen to all members of the practice team. All the partner GPs took it in turn to be "executive partner" to lead on an annual basis.

The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. The duty of candour is a set of specific legal

requirements that providers of services must follow when things go wrong with care and treatment. This included support training for all staff on communicating with patients about notifiable safety incidents. The partner GPs encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

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

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

- Staff told us the practice held regular team meetings. We saw minutes confirming this.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partner GPs 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. We saw that comments and suggestions forms were available in the waiting area and the practice website had facilities for patients to submit them electronically.

The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG was made up of six members. It met every three to four months and submitted proposals for improvements to the practice management team. We saw the 2014/15 annual report, which set out areas identified with the PPG for improvement, including communication with reception staff and appointments running on time. To address communications issues, staff had been given more training, the practice information board in the waiting room was updated more frequently and the website was also updated giving new patients

# Are services well-led?

Good 

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

information on the registration process and the opportunity to print the application form to complete it before attending the practice. To reduce waiting times, the practice had introduced more breaks in GPs' pre-booked appointment sessions, without reducing the number of slots available. This had allowed GPs to improve timekeeping for appointments. In addition, more information was provided to patients using the walk-in service, reminding them that only one health issues could be discussed per slot, thus reducing the time each consultation took up. We discussed the PPG meetings with members, and were told that for most of the recent meetings, no GPs had attended. We saw from minutes that two GPs had been at the June 2015 PPG meeting, but in all other recent cases, the practice had been represented by the practice manager, and deputy or an administrator. PPG members told us they would like more clinical staff attending. We feed this back to the practice, which agreed to address the point. We were told that the walk-in clinics had been introduced following consultation with the PPG and members were very positive regarding the effect the clinics had had on patients' access to the service.

The practice had gathered feedback from staff through staff meetings, appraisals and general discussion. Staff told us

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. For example, a member of staff had requested to be trained as a healthcare assistant and this had been readily supported by the practice.

The practice had submitted proposals to set up a dedicated clinic for patients with musculoskeletal (MSK) problems. The practice had identified a lack of timely specialist assessment and treatment for patients with MSK issues within the local CCG area. One of the GPs, who had an interest in the field, had undertaken specialist training and would be running clinic with a physiotherapist.

The practice was also working with two others nearby to set up an integrated network, to pool knowledge and resources and improve patients' outcomes.