Clerkenwell Medical Practice

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?	Outstanding
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 Clerkenwell Medical Practice on 22 December 2015. 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 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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.

We saw some areas of outstanding practice including:

- The practice had developed an expertise for working with patients living with long term conditions. For example, patients living with HIV and had been recognised as being 'HIV friendly'. Information about this was displayed on their website, where there is also a link to the Terrence Higgins Trust. They had a lead GP who provided education sessions for other GPs around screening, co-morbidity and safe medicines prescribing. Thus enabling patients in this group to have their health needs met in primary care therefore reducing the impact on secondary care services. Another example was, all new diabetic

Summary of findings

patients were referred to the local hospital community diabetic service that provided education and empowerment sessions for patients, to help them understand and better manage their disease. The course for newly diagnosed diabetic patients, was a 6 hour course (either one day or 2 half days). We saw that during the last year 20 patients had been referred to the course and 19 had attended.

- The practice enabled patients to take responsibility for their treatment through the provision of on-line services which included self-referral forms for physiotherapy, podiatry and iCope psychological services.

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

- Ensure that all staff receives relevant role specific training on safeguarding adults.
- Ensure senior staff in the practice receive annual appraisals.
- Ensure that all staff are up to date with basic life support training.
- The practice should consider implementing extended hours appointments to enable greater flexibility for working patients to see a GP.

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.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement.
- Information about safety was highly valued and was used to promote learning and improvement. A slot for significant events was on the weekly clinical meetings and bi -monthly practice meeting agenda and a review of actions from past significant events and complaints was carried out annually.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

Good

The practice is rated good for providing effective services.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice had 'map of medicines' on all computers with links to clinical guidelines and had developed protocols and templates for long term conditions.
- Data showed that the practice performance was better than neighbouring practices in the Clinical Commissioning Group.
- The practice met with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed that patients rated the practice higher than others for some aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

Summary of findings

- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided, to ensure that they meet patients' needs. For example, the practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised such as A&E attendances and prescribing.
- There are innovative approaches to providing integrated person-centred care. The practice had a relatively large cohort of HIV positive patients and as such they had developed an expertise for working with this patient group. They had a lead GP who provided education around screening and co-morbidity. The practice had been recognised as being 'HIV friendly'. Information about this is displayed on their website, where there is also a link to the Terrence Higgins Trust.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, the last survey had identified that patients wanted an increase in the types of appointments available. As a result the practice had increased the number of telephone consultations and was promoting both telephone consultations and the use of double appointments for complex or 2 unrelated issues.
- 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good ●

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to this. Team away days were held every year.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

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.

- Patients over 75 years had a named GP to co-ordinate their care. One GP specifically focused on older people care and carried out home visits when needed.
- A Primary Care Navigator was based at the practice one day a week, to support older patients and their carers to access timely care and community support.
- Double appointments were available for these patients when required.
- There was a community minor surgery service located in the same building which meant GPs were able to refer patients for immediate treatment when needed.

People with long term conditions

Outstanding

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

- The practice was pro-actively managing patients with Long term conditions (LTCs) and had achieved 99.78% points in 2014-15. In addition to QOF LTC disease registers, they held registers for patients with HIV, on anticoagulation, at high risk of CVD or high risk of diabetes, and whose blood pressure was high and had not returned for a review in the last 6 months. The practice recognised that patients with one LTC were at risk of developing other LTCs, they therefore carried out risk stratifying and specific screening. In the last 12 months to 01/12/2015, 88% of patients not eligible for an NHS Health Check due to pre-existing conditions or age and who following risk stratification had a QDiabetes score >15% were recalled for Diabetic Management screening. Seventy four percent of those recalled received screening. Seven newly diagnosed diabetic patients were identified from this cohort
- The practice employed a specialist diabetic nurse to manage their diabetic patients and promote 'Year of Care' management to enable patients to identify their own treatment goals and self-manage their condition. All new diabetic patients were referred to the local hospital community diabetic service that provided education and empowerment sessions. The course

for newly diagnosed diabetic patients, was a 6 hour course (either one day or 2 half days). We saw that during the last year 20 patients had been referred to the course and 19 had attended.

- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. Patients in these groups had a care plan and would be allocated longer appointment times when needed. Reception staff supported clinicians in ensuring annual reviews were completed for all patients in this group.
- The practice had a relatively large cohort of HIV positive patients and as such they had developed an expertise for working with this patient group. They had a lead GP who provided education around screening and co-morbidity. All members of the clinical team used the University of Liverpool drug interaction website to ensure safe medication prescribing.The practice had been recognised as being 'HIV friendly', as traditionally people living with HIV have remained in Secondary Care for their HIV treatment and been reluctant, unwilling, frightened or unaware to register with any GP practice or disclose their HIV status to their GP practice. Information about this was displayed on their website, where there was also a link to the Terrence Higgins Trust.

Families, children and young people

Good

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

- The practice held weekly Child Health clinics, run jointly by the lead GP for Child Protection and attended by the Health Visitors and the Practice Nurse. They recalled all new deliveries for a 6 week check to ensure both baby and maternal health needs are identified early.
- Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, they would refer families for additional support and had multidisciplinary meetings with health visitors where any safeguarding concerns would be discussed.
- The practice offered all children under five an automatic appointment to see a doctor on the same day, if requested. If no appointments were available they were added as an extra to the duty doctor's list.
- The GPs demonstrated an understanding of Gillick competency and told us they promote sexual health screening.

Summary of findings

Working age people (including those recently retired and students)

Good

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

- The practice offered on-line services which included appointment management, repeat prescriptions, registration and self-referral forms for physiotherapy, podiatry and iCope psychological services.
- Patients had access to NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

People whose circumstances may make them vulnerable

Good

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

- The GPs told us that patients whose circumstances may make them vulnerable such as the homeless, those under safeguarding or people with learning disabilities were offered regular health checks and follow-up.
- They offered longer appointments for patients with a learning disability. Patients with learning disabilities were invited annually for a specific review with their named GP. We saw 100% of reviews had been carried out in the last 12 months.
- The practice care navigator informed vulnerable patients about how to access various support groups and voluntary organisations.
- 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 also had a higher than national average rate of patients who had drug and alcohol issues. There was a specialist nurse for drug and alcohol issues employed by the practice and there was a named GP to provide liaison and oversee the prescribing of methadone (a medicine for drug addiction).

People experiencing poor mental health (including people with dementia)

Outstanding

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

Summary of findings

- The practice local population had a high mental health prevalence, including Serious Mental Health. These patients had a named GP to enable continuity and provide a comprehensive approach to both their mental and often increased physical health needs. The practice also had access to the Crisis mental health team for patients who were acutely unwell and they felt were at risk and had a psychology services on-site to which patients can self-refer.
- Both clinical and non-clinical staff had recently completed specialist training offered by the Personality Disorder service to educate, understand and respond to this group of patients and their behaviours.
- For patients with concerns about memory and function, they had created a standardised blood test form to aid prompt access to the memory clinic. The practice had good links with the memory service and had individualised care plans for these patients.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing slightly above local and national averages. There were 98 responses and a response rate of 24%.

- 83% found it easy to get through to this surgery by phone compared to a CCG average of 76% and a national average of 73%.
- 89% found the receptionists at this surgery helpful compared to CCG average of 86% and a national average 87%
- 90% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average 83% and a national average 85%
- 89% said the last appointment they got was convenient compared to a CCG average 87% and a national average 92%.
- 79% described their experience of making an appointment as good compared to a CCG average 69% and a national average 73%.
- 62% usually waited 15 minutes or less after their appointment time to be seen (CCG average 60%, national average 65%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were all positive about the standard of care received. Patients felt the practice offered an excellent service and staff were considerate and treated them with dignity and respect

We spoke with eight patients during the inspection. All said that they were happy with the care they received and thought staff were approachable, committed and caring.

Outstanding practice

- The practice had developed an expertise for working with patients living with long term conditions. For example, patients living with HIV and had been recognised as being 'HIV friendly'. Information about this was displayed on their website, where there is also a link to the Terrence Higgins Trust. They had a lead GP who provided education sessions for other GPs around screening, co-morbidity and safe medicines prescribing. Thus enabling patients in this group to have their health needs met in primary care therefore reducing the impact on secondary care services. Another example was, all new diabetic patients were referred to the local hospital community diabetic service that provided education and empowerment sessions for patients, to help them understand and better manage their disease. The course for newly diagnosed diabetic patients, was a 6 hour course (either one day or 2 half days). We saw that during the last year 20 patients had been referred to the course and 19 had attended.
- The practice enabled patients to take responsibility for their treatment through the provision of on-line services which included self-referral forms for physiotherapy, podiatry and iCope psychological services.

Clerkenwell 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 advisor, an expert by experience and another CQC inspector.

Background to Clerkenwell Medical Practice

Clerkenwell Medical Practice provides GP primary care services to approximately 9400 people living in Islington. The practice is staffed by eight GPs, three male and five female who work a combination of full and part time hours totalling 4.5 WTE. The practice is a training practice and employs two trainee GPs. Other staff included three nurses, a health care assistant, a clinical performance manager, a practice manager and nine administrative staff. The practice holds a General Medical Services (GMS) contract and was commissioned by NHSE London. The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury and maternity and midwifery services.

The practice was open from 8.30am to 6.30pm Mondays, Tuesdays, Thursday and Fridays. On Wednesday they were open 8.30am to 5pm. They do not currently offer any extended hours. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours, but on Wednesdays the phones went through to the OOH service at 1pm who would contact the GPs directly if a patient needed to see someone urgently. The out of hours services are provided by an alternative provider. The details of the 'out of hours' service are communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. Patients can book appointments and order repeat prescriptions online.

The practice provided a wide range of services for patients with diabetes, HIV, mental health, chronic obstructive pulmonary disease (COPD), contraception and child health care. The practice also provided health promotion services including a flu vaccination programme and cervical screening.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting we reviewed a range of information we hold about the service and asked other organisations such as Healthwatch, to share what they knew about the service. We carried out an announced visit on 22 December 2015. During our visit we:

Detailed findings

- Spoke with a range of staff (doctors, nurse, practice manager and receptionists) and spoke with patients who used the service.
- Reviewed policies and procedures, records and various documentation.
- Reviewed Care Quality Commission (CQC) comment cards where patients shared their views and experiences of the service.

  To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

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

The practice used a range of information to identify risks and improve patient safety.

- They had processes in place for documenting and discussing reported incidents and national patient safety alerts, as well as comments and complaints received from patients. Staff were encouraged to log any significant event or incident and we saw there was a template located on all desk tops for all staff to complete when an incident occurred. Staff we spoke with were aware of their responsibilities to bring them to the attention of the practice manager. These were usually discussed on the day they occurred and at the weekly clinical meetings and bi- weekly administration meetings. Emails were sent out to staff not present on the day.
- The practice carried out a thorough analysis of the significant events on an bi-annual basis and sent annual reports to the CCG.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. We saw appropriate action was taken to improve safety in the practice. For example, we saw there was an incident where the practice vaccine fridge was damaged as a result of a building maintenance issue. The practice took appropriate action with the fridge and vaccines. We saw all staff were informed of the incident and action taken.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard patients from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. All staff had received child protection training; clinicians were trained to level 3 and non-clinicians level 1. However, we found on the day of our inspection some staff had not received relevant role specific training on safeguarding adults. All staff we spoke with knew how to recognise signs of abuse, they were also aware of their responsibilities and knew how to share information, record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were located in intranet pages and displayed on the walls in reception and treatment rooms. The lead GP attended all external safeguarding meetings.
- A chaperone policy was in place and there were visible notices on the waiting room noticeboard and in consulting rooms. If the practice nursing staff were not available to act as a chaperone, administration staff had been asked to carry out this role on occasions. The practice nurse provided chaperone training to the administrative staff members. All staff we spoke with understood their responsibility when acting as chaperones, including where to stand to be able to observe an examination. All staff providing these duties had been Disclosure and Barring Service checked. (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).
- Appropriate standards of cleanliness and hygiene were followed. There was an infection control policy and protocols in place. We observed the premises to be clean and tidy. The practice nurse was the infection control lead role and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training.Most staff had received training.The practice completed regular audits and we saw evidence that action was taken to address any improvements identified as a result.Cleaning of the practice was the responsibility of the landlords NHS property service and we were told the practice was cleaned daily, and the toilets were also checked regularly throughout the day and cleaned when needed.
- The arrangements for managing medicines, including emergency medicines and vaccinations, in the practice

kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Vaccines were stored in medicine refrigerators in the nurse's treatment rooms. There was a clear policy for ensuring medicines were kept at the required temperatures. We saw records to confirm that temperature checks of the fridges were carried out daily to ensure that vaccinations were stored within the correct temperature range. There was a clear procedure to follow if temperatures were outside the recommended range and staff were able to describe what action they would take in the event of a potential failure of the fridge. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

- The GPs and nurses shared latest guidance on medicines and prescribing practice at weekly clinical meetings, for example the prescribing of antibiotics. The practice regularly liaised with the commissioning support unit pharmacist for prescribing advice and support and we saw their prescribing levels were comparable to other local practices. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment)
- Recruitment checks were carried out and the six files we reviewed showed that appropriate check had been carried out prior to employment.

Monitoring risk 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 a health and safety policy which staff were required to read as part of their induction.There was a fire risk assessment in place, all fire equipment had been serviced within the last year and a fire drill had taken place in August 2015.There was 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. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment testing (PAT) had been carried out in 2013 and had been booked for January 2016. Since the inspection we have received evidence to confirm this has now taken place. We saw evidence of calibration of relevant equipment; for example, blood pressure monitors, ECG, weighing scales and pulse oximeter which had been carried out in December 2015.
- The lead GP told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. We saw that where they had an increase in patient numbers non- clinical and clinical staff had been increased. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. For example, the administrator provided cover for the receptionist for all absences and the practice manager told us they would provide cover on reception when necessary.

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.
- Staff received annual basic life support training, however some staff were overdue their refresher course, but we saw evidence to confirm this had been booked for February 2016.
- The practice had a defibrillator available on the premises and oxygen with adult and child masks. There was also a first aid kit and a spill kit available at reception.

Good

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

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 GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw the practice had 'map of medicines' on all computers with links to clinical guidelines and had developed protocols and templates for long term conditions. The practice also had weekly clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.
- 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 employed a clinical performance manager who provided information about performance to the clinical team. They used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available, with 10% exception reporting. (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. The QOF data 2014/15 showed;

- Performance for diabetes related indicators was 98% which was 9.9% above the CCG and 7.7% above national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100% which was 3.3% above the CCG average and 2.1% above national average.
- Performance for mental health related indicators was 100% which was 7.7% above the CCG average and 7.2% above the national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes.

- There had been more than ten clinical audits carried out in the last year.Three were completed where the improvements made were implemented and monitored. For example, the practice had carried out an anticoagulation audit to ensure that all patients prescribed the anti-coagulant Warfarin were on the practice register and regularly monitored regarding duration of treatment and target International Normalised Ratio (INR). On first audit they found there were 37 patients being prescribed warfarin and only 23 on the register, on re-audit all patients were on the register and 36 had up to date reviews on record.
- The practice attended monthly benchmarking groups run by the CCG. Performance data from the practice was evaluated and compared to similar surgeries in the area.

Effective staffing

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

- The practice had an induction programme which covered a wide range of topics such as health and safety, infection control and fire safety.
- 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 these learning needs and to cover the scope of their work. Most staff had had an appraisal within the last 12 months, however we noted there were no records to evidence that the nurse and the practice manager had been appraised.
- The nurse who administered vaccinations and took samples for the cervical screening programme had received specific training which had included an

assessment of competence. They had attended refresher training and accessed on line resources to ensure they stayed up to date with changes to the immunisation programmes.

- Staff also completed regular mandatory courses such as annual basic life support, fire procedures and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. The practice manager kept a training matrix and was therefore aware of when staff needed to complete refresher training in these topics. However, we noted that all staff were up to date with adult safeguarding and basic life support 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 test results.
- All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. All patients deemed vulnerable or with complex needs had care plans which they had been involved in drafting. They included information about how to manage their conditions. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. The health visitors were based in the same building as the practice and confirmed they met regularly with the GP's to discuss care planning concerns and often had ad hoc discussions when they had serious concerns about patients.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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 (MCA). Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. We saw evidence of this in patient's records.
- The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.
- The practice also documented in patients notes if they had refused a chaperone when offered.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- A care coordinator was available at the practice two days a week and smoking cessation advice was available at the practice.

The practice's uptake for the cervical screening programme was 74%, which was above the CCG average of 72% and below the national average of 81%. There was a policy of sending a first letter, followed by a text, then a second and third letter to patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 59% to 82% and five year olds from 48% to 76%. Flu vaccination rates for the over 65s were 59%, and at risk groups 31%. These were however below the CCG and national averages. The practice told us their take up of flu vaccination this year was considerably lower than last year due to a number of their patients having these carried out elsewhere and had not informed them.

Good

Are services effective?

(for example, treatment is effective)

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

A wide range of information was displayed in the waiting area of the practice and on the practice website to raise awareness of health issues including information on cancer, fever in children and influenza. There was also information about local health and community resources.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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, however we noted that conversations taking place in one of the treatment rooms could 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.

All of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were considerate and treated them with dignity and respect.

We spoke with two members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey from 2015, the practices internal patient survey and the results from the NHS Friends and Family Test where 81% patients said they would recommend this practice.

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

- 86% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 81% said the GP gave them enough time compared to the CCG average of 82% and national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average 95% and national average 95%
- 88% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average 83% and national average 85%.
- 78% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average 84% and national average 91%.
- 89% said they found the receptionists at the practice helpful compared to the CCG average 86%, national average 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 90%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average 82%.

However, only 57% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average 85%.

Good

Are services caring?

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 website also had information available in a number of different languages.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 12% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them. We also noted the practice held occasional carer's information events.

Staff told us that all patients deaths were discussed at the weekly clinical meeting and if families had suffered bereavement, their usual GP contacted them and 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.

Outstanding ☆

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.

For example the practice attended a monthly locality meeting with the Clinical Commissioning Group (CCG) and other practices to discuss local needs and plan service improvements that needed to be prioritised such as A&E attendances and prescribing.

- Patients over 75 years had a named GP to co-ordinate their care. One GP specifically focused on older people care and carried out home visits when needed. A Primary Care Navigator was based at the practice one day a week, to support older patients and their carers to access timely care and community support. Their role included befriending, attending patients' homes, liaising with social services and acting as advocates. Double appointments were available for these patients when required and there was a community minor surgery service located in the same building which meant GPs were able to refer patients for immediate treatment when needed.
- The practice held registers for patients in receipt of palliative care, had complex needs or had long term conditions. Patients in these groups had a care plan and would be allocated longer appointment times when needed. Reception staff supported clinicians in ensuring annual reviews were completed for all patients in this group.
- The practice was pro-actively managing patients with Long term conditions (LTC) and had achieved 99.78% QOF points in 2014-15. In addition to QOF LTC disease registers, they held registers for patients with HIV, on anticoagulation, at high risk of Cardio Vascular Disease or high risk of diabetes, and whose blood pressure was high and had not returned for a review in the last 6 months. The practice nurse was the lead on managing patients with Chronic Obstructive Pulmonary Disease (COPD) and asthma. We saw that all COPD patients were referred to pulmonary rehabilitation, had an annual review in the last twelve months which included a holistic review of their specific needs, education and were offered 'rescue packs' in case of exacerbations.
- The practice takes part in the Locally Commissioned Services for LTC which were services provided by GPs commissioned by theCCG over and above those services that GPs provide as per their contract with NHS England. This scheme recognises that patients with one LTC are at risk of developing other LTCs and seeks to close the prevalence gap for other undiagnosed LTCs in this group by risk stratifying and specific screening. For example, in the last 12 months to 01/12/2015, 88% of patients not eligible for an NHS Health Check due to pre-existing conditions or age and who following risk stratification had a QDiabetes score>15% were recalled for DM screening. 74% of those recalled received screening. Seven newly diagnosed diabetic patients were identified from this cohort.
- The practice employed a specialist diabetic nurse to manage their diabetic patients and promote 'Year of Care' management to enable patients to identify their own treatment goals and self-manage their condition. All new diabetic patients were referred to the local hospital community diabetic service that provided education and empowerment sessions for patients, to help them understand and better manage their disease. The course for newly diagnosed diabetic patients, was a six hour course (either one day or two half days). We saw that during the last year 20 patients had been referred to the course and 19 had attended.
- The practice had a relatively large cohort of HIV positive patients and as such they had developed an expertise for working with this patient group. They had a lead GP who provided education around screening and co-morbidity. All members of the clinical team use the University of Liverpool drug interaction website to ensure safe medicines prescribing.The practice had been recognised as being 'HIV friendly', as traditionally people living with HIV have remained in Secondary Care for their HIV treatment and been reluctant, unwilling, frightened or unaware to register with any GP practice or disclose their HIV status to their GP practice. Information about this was displayed on their website, where there was also a link to the Terrence Higgins Trust.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held weekly Child Health clinics, run jointly by the lead GP for Child Protection and attended by the Health Visitors and the Practice Nurse. They recalled all new deliveries for a 6 week check to ensure both baby and maternal health needs are identified early. All doctors were updated on Child Protection issues at the weekly clinical meetings and the Health Visitors attended on a monthly basis. They also had Healthy Start vitamins available at the practice.
- Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, they would refer families for additional support and had multidisciplinary meetings with health visitors where any safeguarding concerns would be discussed.
- The practice offered all children under 5 an automatic appointment to see a doctor on the same day, if requested. If no appointments were available they were added as an extra to the duty doctor's list.The GPs demonstrated an understanding of Gillick competency and told us they promoted sexual health screening .
- The practice offered on-line services which included appointment management, repeat prescriptions, registration and self-referral forms for physiotherapy, podiatry and iCope psychological services.
- The GPs told us that patients whose circumstances may make them vulnerable such as people with learning disabilities, patients who do not have English as their first language (6% of the practice population is Chinese and 5% African), were coded on appropriate registers. Pop up alerts were placed on all computer notes to alert all members of staff of vulnerable patients. GPs told us this was to allow them to meet their specific additional needs such as double appointments, interpreter, visual/ hearing impaired, carer details, and risk assessment stratification. Patients with learning disabilities were invited annually for a specific review with their named GP. We saw 100% of reviews had been carried out in the last 12 months.
- We saw that in the weekly clinical team meetings there were discussions on, all new cancer diagnoses and end of life issues. The Palliative care register patients details would then be updated on "Coordinate my Care" so that the London Ambulance Service were aware of any health concerns.
- The practice local population had a high mental health prevalence, including Serious Mental Health issues. These patients had a named GP to enable continuity and provide a comprehensive approach to both their mental and often increased physical health needs. Patients at risk of or had recent deliberate self-harm episodes were discussed in the weekly clinical meetings. The practice also had access to the crisis mental health team for patients who were acutely unwell and they felt were at risk.They also had a psychology services on-site to which patients can self-refer. We saw both clinical and non-clinical staff had recently completed specialist training offered by the Personality Disorder service to educate, understand and respond to this group of patients and their behaviours.
- The practice also had a higher than national average rate of patients who had drug and alcohol issues. There was a specialist nurse for drug and alcohol issues employed by the practice and there was a named GP to provide liaison and oversee the prescribing of methadone (a medicine for drug addiction).
- For patients with concerns about memory and function, they had created a standardised blood test form to aid prompt access to the memory clinic. The practice had good links with the memory service, used navigators to help patients and their carers and had individualised care plans for these patients.
- The premises were accessible to patients with disabilities and there was a hearing loop installed. The waiting area was large enough to accommodate patients with wheelchairs and allowed for easy access. Accessible toilet facilities were available for all patients attending the practice.

Access to the service

The practice was open from 8.30am to 6.30pm Mondays, Tuesdays, Thursday and Fridays. On Wednesday they were open 8.30am to 5pm. Although the practice did not have extended hours appointments, they offered telephone access to a named GP within 48 hours. The telephones were staffed throughout working hours. Appointment slots were available throughout the opening hours, but on Wednesdays the phones went through to the OOH service at 1pm who would contact the GPs directly if a patient needed to see someone urgently. The out of hours services are provided by an alternative provider. The details of the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

'out of hours' service were communicated in a recorded message accessed by calling the practice when closed and details can also be found on the practice website. The practice was promoting both telephone consultations and the use of double appointments for complex or 2 unrelated issues. This included appointments with a named GP or nurse. Pre-bookable appointments could be booked up to four weeks in advance; urgent appointments were available for people that needed them as there was a daily duty GP. People who worked in the area but lived elsewhere could also register with the practice.

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

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 68% and national average of 75%.
- 83% patients said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.
- 56% patients said they always or almost always see or speak to the GP they prefer compared to the CCG average of 53% and national average of 59%.

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

Listening and learning from concerns and complaints

The practice had a 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. However, all verbal complaints were not recorded.
- The practice manager handled all complaints in the practice. We saw that these were analysed on an annual basis and the outcome and actions were discussed with all members of staff.
- We saw that information was available to help patients understand the complaints system, for example posters were displayed on notice boards and there was information available to patients on the practice leaflet when they registered. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at a sample of complaints received in the last 12 months and found these were dealt with in a timely way, in line with the complaints policy and there were no themes emerging. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we saw that when it was highlighted that receptionists were unable to advise patients on how to set up online services, the practice provided training for the reception team.

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 vision and values was 'nothing is too good for ordinary people'. All staff we spoke with knew and understood the vision and values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were monitored at their away day.

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 responsibilitiesWe spoke with seven members of staff and they were all clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.
- The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. Staff had to read the key policies such as safeguarding, health and safety and infection control as part of their induction.All five policies and procedures we looked at had been reviewed and were up to date.
- The practice used the Quality and Outcomes Framework (QOF) to measure their performance.The QOF data for this practice showed it was performing above national standards. They had scored 882 out of 900 in 2014 and 555 out of 559 in 2015 which was 5.6% above the CCG average and 5.8% above England average. We saw QOF data was regularly reviewed and discussed at the weekly clinical and monthly practices meetings. The practice also took part in a peer reviewing system with neighbouring GP practices in Islington.
- There was a programme of continuous clinical and internal audit used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, all patients deemed vulnerable had a care plan and risk assessments in their records.

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty and there were systems in place to ensure all staff were made aware of notifiable safety incidents.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

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

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

- Staff told us that the practice held regular team meetings. We saw from minutes that Clinical Meetings were held weekly and Partners Meetings were held monthly.
- Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.. they felt they worked well together and were a highly functional team which listed and learnt, and were aware of their areas for improvement, such as the need to increase their surgery sessions in line with their increasing patient list.
- We noted that team away days were held every year and staff told us these days were used both to assess business priorities and socialise with colleagues.

Are services well-led?

Good

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

- Staff said they felt respected, valued and supported, particularly by the management in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the last survey had identified that patients wanted an increase in the types of appointments available. As a result the practice had increased the number of telephone consultations and was promoting both telephone consultations and the use of double appointments for complex or two unrelated issues.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was better than local and national averages. For example 79% patients described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff at all levels were actively encouraged to raise concerns. All staff we spoke with told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice nurse had completed Primary Care Mentorship training. The mentorship was part of a drive to educate secondary care nurses so they could move into primary care. We saw that a trainee nurse was due to start at the practice in February 2016. They were also a training practice for GPs and at the time of our inspection they employed two trainee GPs.

We found there was a strong culture of support and staff development at the practice, all partners had attended leadership training. One GP was also a lecturer in primary care and population health.

A systematic approach was taken in working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. Some partners were involved in various external boards and organisations such as CCG and Local Commissioning Group (LCG) boards. We saw that information from all these forums were fed back to practice staff at weekly clinical meetings and monthly partners meetings.