The Goodinge Group 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?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Goodinge Group Practice on 22 April 2015.

Overall the practice is rated as Good. Specifically, we found the practice to be good for providing, safe, effective, caring, responsive and well-led services. It was also good for providing services to the six population groups we looked at: 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; and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Patients were protected from risk of harm because systems and processes were in place to keep them safe.
- Staff were clear about reporting incidents, near misses and concerns and there was evidence of communication of lessons learned with staff.
- The practice worked in collaboration with other health and social care professionals to support patients' needs and provided a multidisciplinary approach to their care and treatment.
- The practice promoted good health and prevention and provided patients with suitable advice and guidance.
- The practice had several ways of identifying patients who needed additional support, and was pro-active in offering this.
- The practice provided a caring service. Patients indicated that staff were caring and treated them with dignity and respect. Patients were involved in decisions about their care.
- The practice provided appropriate support for end of life care and patients and their carers received good emotional support.
- The practice learned from patient experiences, concerns and complaints to improve the quality of care.
- The practice had a clear ethos that put patients first and was committed to providing the best possible service to them.

Summary of findings

- There was an open culture and staff felt supported in their roles.

However, there were also areas of practice where the provider needs to make improvements which are:

- Develop the practice's own policy for safeguarding of vulnerable adults;
- Ensure the records of interview and selection decisions are retained;
- Complete the consideration of future provision of mandatory staff training and make arrangements for update training in areas where there are currently some gaps, for example, in fire safety and infection control training;
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account; and
- Ensure the practice's mission statement is communicated to all staff.

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. The practice had an effective system in place for managing significant events, incidents and accidents and for communicating lessons learned to support improvement. There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The practice had an appropriate policy in place for safeguarding children. The practice did not have its own policy for safeguarding of vulnerable adults but used the Islington Safeguarding Adults Guide for GPs. Staff had undergone recent training in safeguarding both children and vulnerable adults. Arrangements were in place to ensure medicines were stored securely and were only accessible to authorised staff. Prescriptions were kept securely. There were appropriate infection control policies and procedures in place. The practice had appropriate processes for recruiting staff, including evidence of the required pre-employment checks. However, the records of interview and selection decisions were not retained. Risks to patients and staff were assessed and appropriately managed.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice scored positively in several areas of their QOF performance and where lower scores were achieved used QOF to steer practice activity. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. The practice participated in clinical audit and routinely collected information to review and improve patient care and outcomes. The practice worked in collaboration with other health and social care professionals to provide a multidisciplinary approach to their care and treatment. The practice had a consent protocol which staff were aware of and followed. There were appropriate arrangements in place to support staff appraisal, learning and professional development, although there were some gaps in mandatory training staff had received. The practice promoted good health and prevention. Immunisation rates for at risk groups and children were in line with CCG and national averages.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the national GP patient survey showed the practice was rated broadly in line with or above the CCG and national average for dignity and respect, and above average for involvement in decisions and emotional support in their care and treatment. Feedback from patients during the inspection was mostly positive about the services they received. Patients indicated that staff were caring and treated them with dignity and respect and involved them in decisions about their care and treatment. We observed during the inspection that staff treated patients with kindness sensitivity and respect, and maintained confidentiality. The practice provided appropriate support for end of life care and patients and their carers received good emotional support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) in particular with regard to the appointments system. The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments. The national patient survey showed patients responded positively to questions about access to appointments and generally rated the practice well in this area. The premises and services had been adapted to meet the needs of people with disabilities. There was an effective complaints system, and information about the complaints procedure was made readily available to patients. Lessons learned were communicated to staff when individual complaints were concluded.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear ethos which involved putting patients first and was committed to providing them with the best possible service. The practice's aims were set out in its mission statement and staff were committed to these aims. There were governance arrangements in place through which risk and performance monitoring took place and service improvements were identified. The practice had a range of policies and procedures to govern activity which were regularly reviewed. There was a clear leadership structure with named members of staff in lead roles. There was an open culture, staff were clear about their own roles and responsibilities and felt supported in their work. There were arrangements for identifying, recording and managing risks. A disaster handling and recovery plan was in place to deal with

Summary of findings

a range of emergencies that may impact on the daily operation of the practice. Staff had received induction training and regular performance reviews. The practice proactively sought feedback from staff and patients, including a patient participation group (PPG), which it acted on. The practice had a whistleblowing policy and staff we spoke with were aware of the policy.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. The practice held regular multidisciplinary team meetings to discuss patients with complex needs including elderly and frail patients and those with end of life care needs. All patients aged over 75 were offered an annual health check, which could be carried out at home if needed. For older patients and patients with long term conditions home visits were available if required. Flu vaccinations were provided to older people in at-risk groups. Patients visiting the older people's charity day centre next door to the practice were seen by clinical staff on the day if requested by day centre staff. Frail patients were seen by the duty doctor on the day if they attended the practice for an urgent appointment. There were effective arrangements in place to support carers.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Structured annual reviews were undertaken for patients with long term conditions, including diabetes, COPD, and heart failure. The practice held weekly video conference multidisciplinary team meetings to discuss patients with complex needs including those with multiple long term conditions. The practice provided a range of services for patients with chronic health problems. Nurse-led reviews were offered for asthma, COPD, stable diabetes, blood pressure and heart disease. The practice kept a register of patients identified as being at high risk of admission to hospital, including patients with long term conditions. There was on-site access to a range of services for patients with long term conditions. This included district nurses, a leg ulcer clinic, an anticoagulation clinic, retinal screening for diabetic patients, and a dietician.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice ran an antenatal clinic and appointments. There was a weekly child health clinic and a walk in service for mothers who wished to speak with a health visitor (based at the premises) or wanted their baby weighed. Invites for the maternal post natal check and six week baby check appointment were sent out on receipt of the maternity discharge from hospital. Sick children were prioritised for urgent appointments and generally children under one year were seen at the surgery. The practice provided a smear testing service and its performance for cervical smear uptake was 74%, which was below the national average of

Summary of findings

82%. The practice was taking action to address this. There were procedures in place to safeguard children and young people from abuse. Both clinical and non-clinical staff had received child protection training in line with national guidance. There was a system to highlight vulnerable patients on the practice's electronic records, including vulnerable families and children at risk. There were regular meetings with health visitors and other health and social care professionals to review at risk children. Practice staff had participated in the Identification and Referral to Improve Safety (IRIS) programme, a general practice-based domestic violence and abuse training support and referral programme.

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 was accessible to working people. For example, the practice provided a Saturday morning surgery from 9:00am to 1:00pm and one early morning surgery a week from 7:20am to 8:00 am. Appointments could be booked on line and repeat prescriptions ordered electronically. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Where appropriate, patients were referred to a local exercise referral scheme, which provided supervised exercise sessions. The practice participated in the Islington Stop Smoking local commissioned scheme (LCS) and had a number of trained smoking advisers who patients could see for support and advice. The practice encouraged its patients to attend national screening programmes, including bowel cancer and mammography screening. Flu vaccinations were offered to patients aged 65 and older and the practice provided travel vaccinations and advice. The practice also provided 'catch up clinics' for immunisations for teenagers and students.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice kept a register of patients with learning disabilities to enable their care and treatment needs to be kept under review. These patients (including those with dementia) were supported to make decisions through the use of care plans, which they were involved in agreeing. One of the practice's nurses visited a local homeless charity to carry out health checks on residents. The practice facilitated 'in-house' access to benefits and welfare advice through the Citizen's Advice Bureau (CAB).Staff knew how to recognise signs of abuse and the process to follow in the event of any safeguarding concerns. Staff had been trained in safeguarding of vulnerable adults. If needed, translation services were available for patients who did not have English as a

Summary of findings

first language. The practice web-site provided access to NHS fact sheets in different languages explaining the role of UK health services and the National Health Service (NHS), to newly-arrived individuals seeking asylum. Under the practice's registration policy all new patients were welcomed provided they lived in the practice's catchment area. Patients with no fixed abode could use the practice address to register. The premises and services had been adapted to meet the needs of people with disabilities.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice kept a register of patients with mental health problems to enable their care and treatment needs to be kept under review. These patients (including those with dementia) were supported to make decisions through the use of care plans, which they were involved in agreeing. There was also a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with mental health problems. The practice's consent protocol did not make specific reference to the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent. However, guidance and in-house training had been provided to all staff regarding the Act and deprivation of liberty safeguards (DoLS) and staff were aware of the Act with regard to consent and best interest decisions. The practice maintained close contact with mental health workers and there was a psychology mental health nurse and consultant on site. Patients also had access to an on-site drug/alcohol dependence nurse weekly. One of the practice nurses was mental health trained and contacted all patients on the mental health register to arrange an annual appointment for health promotion and blood checks.

Summary of findings

What people who use the service say

We received 23 completed comment cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good or excellent service and staff were polite, efficient, helpful and caring. They said staff treated them with dignity and respect. The cleanliness of the premises was also praised. Two patients complimented the service but said waiting times could be lengthy and communication with health visitors could be improved. One patient was unhappy with their medication. We also spoke with 11 patients on the day of our inspection, including two members of the patient participation group (PPG). The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some comments were less positive for example about the appointment system and the promotion of on-line services.

In the national patient survey 2014/15 patients views were generally positive. They were broadly satisfied with their treatment regarding consultations with doctors and nurses. They rated the practice well for involvement in planning and making decisions about their care and treatment, emotional support, access to appointments and waiting times. Respondents to the survey were less positive regarding access to their preferred doctor. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. These included improved phone access by upgrading the phone system to include an improved queuing system and an increased number of lines; quicker phone access by increasing the number of receptionists answering the phones, especially during the peak times; better promotion of on line services to make patients more aware of alternative ways to book appointments and request repeat prescriptions; and better access to the service by the take on a new partner to meet an increase in patient list size.

In the latest NHS Friends and Family test 96% of 51 patients who responded recommended the practice.

Areas for improvement

Action the service SHOULD take to improve

- Develop the practice's own policy for safeguarding of vulnerable adults;
- Ensure the records of interview and selection decisions are retained;
- Complete the consideration of future provision of mandatory staff training and make arrangements for update training in areas where there are currently some gaps, for example, in fire safety and infection control training;
- Review the practice's consent protocol to ensure mental capacity is appropriately taken into account; and
- Ensure the practice's mission statement is communicated to all staff.

The Goodinge Group 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, a practice specialist, and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service. The GP, practice specialist and expert by experience were granted the same authority to enter the practice as the CQC inspector.

Background to The Goodinge Group Practice

The Goodinge Group Practice provides primary medical services through a General Medical Services (GMS) contract to around 12,600 patients in the Islington area of London. The practice has an ethnically diverse patient population. There are high rates of deprivation within the CCG area and above CCG and national averages within the practice's catchment area. There has been a significant rise in the number of patients registering with the practice in the last four years. In 2014/15, 2287 new patients registered and this had put pressure on staffing resources and premises.

The practice is registered to carry on the following regulated activities: Diagnostic and screening procedures; Maternity and midwifery services; and Treatment of disease, disorder or injury.

The practice team is made up of a team eight GP partners (six female and two male). There was also a locum GP employed at the time of the inspection. The practice employs a practice manager, reception manager, three nurses, a health care assistants, plus reception and administrative staff.

The practice is a training practice and there was a trainee registrar placement at the practice at the time of our inspection.

The surgery is open and appointments are available at the practice from 8:30am to 1:00pm and from 2:00pm to 6.30pm on Monday to Friday. There is also a Saturday morning surgery from 9:00am to 1:00pm and one early morning surgery a week from 7:20am to 8:00 am. Both of these clinics are for pre-bookable appointments only. A duty doctor is in the practice until 6:30pm Monday to Friday.

Out of hours services are provided by a local provider. Access to the service is via the national NHS 111 call line. The NHS 111 team will assess the patient's condition over the phone and if it is clinically appropriate, will refer the case to the out of hours service.

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. This 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.

Detailed findings

How we carried out this inspection

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 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
- 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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We liaised with NHS Islington Clinical Commissioning Group (CCG), Healthwatch Islington and NHS England.

We carried out an announced visit on 22 April 2015. During our visit we spoke with 11 patients and a range of staff including four GP partners, a trainee registrar, nurse and health care assistant, the practice manager, and reception staff. We reviewed 23 comments cards where patients who visited the practice in the week before the inspection gave us their opinion of the services provided. We observed staff interactions with patients in the reception area. We looked at the provider's policies and records including, staff recruitment and training files, health and safety, building and equipment maintenance, infection control, complaints, significant events and clinical audits. We reviewed personal care plans and patient records and looked at how medicines were recorded and stored.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw evidence of incident reports documented for the last 12 years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events and a summary was made available to us before the inspection for events that had occurred during the last year. These records provided a description of the nature of each event, the action taken and the learning points identified and implemented. Staff we spoke with told us the outcomes of significant events were discussed with them. We were told also that any significant events would be discussed at practice meetings and lessons learned communicated. We saw evidence of this in the minutes of partners meetings we looked at and such events were a permanent item on the agenda of these meetings. Where appropriate incidents and lessons learned were also reviewed at administrative staff meetings. We saw evidence of this, for example relating to an incident with a patient in the reception area which resulted in an external service visiting the practice to help staff in dealing with future incidents.

The practice had an incident reporting procedure which included the use of an incident reporting form. The forms were available on the practice computer system and completed forms were kept in an incident folder. We saw records were completed in a comprehensive and timely manner and included details of outcomes and action taken. For example, due to a practice oversight the system for receiving documents electronically from the local acute hospital was locked and documents including discharge summaries could not be retrieved. As soon as the problem was discovered the practice promptly arranged for doctors to review and take necessary action on the backlog of documents. Arrangements were put in place for the administrative team to check the system remained open and troubleshoot any problems. The incident was discussed within the practice to ensure staff were vigilant in ensuring access to the system was not compromised again.

We noted that doctors completed a significant event audit structured reflective template of events they were involved in. This enabled them to reflect on what well, what could have been done better, what changes have been agreed and the implications for the practice team. The audits were shared with the practice team at partner meetings and the audit forms recorded when this had taken place. We saw evidence of this in minutes of four meetings when a significant event was discussed. The final outcome of the audit was considered as part of the doctor's appraisal for revalidation.

There were appropriate systems for managing and disseminating patient safety alerts and guidance issued by the National Institute for Health and Care Excellence (NICE). The practice manager reviewed all alerts and guidelines and emailed anything relevant to the practice to the GP partners and nurses. There was also a nominated GP partner responsible for reviewing relevant alerts and guidelines and deciding how to disseminate the information within the practice. Where appropriate the alert or guidance would be put on the agenda for the next partners meeting for discussion and review of any changes in practice required. We saw evidence of this in the minutes of a meeting when four MHRA medicines alerts were discussed and action taken in relation to patients affected was recorded.

Reliable safety systems and processes including safeguarding

The practice had a child protection protocol in place which included contact details for local safeguarding agencies. The practice did not have its own policy for safeguarding of vulnerable adults. However, the practice referred to the Islington Safeguarding Adults Guide for GPs which was available to all staff on the practice's computer and included adult social services contact details. The practice had a nominated GP who was the lead for safeguarding of both children and vulnerable adults. Staff we spoke with knew who the lead was, how to recognise signs of abuse and the processes to follow. Details of local safeguarding contacts were available to staff in the reception area and staff we spoke with were aware of this information. Staff

training records indicated that the majority of staff had undergone safeguarding children training. GPs received training at level 3 nurses at level 2, which met with national guidance. The safeguarding lead was trained at level 4. Administrative staff were trained at level 1. Recently recruited staff had not received child protection training, but we were told this was being arranged. In addition, apart from one GP, one nurse and small number of administrative staff, the majority of staff had completed formal training in safeguarding of vulnerable adults.

There was a system to highlight vulnerable patients on the practice's electronic records, including vulnerable families and children at risk. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We saw evidence of this on a sample patient records we reviewed. There was also a process to record and monitor on patient records when a child has not attended for a hospital appointment. This was to identify recurrent patterns of non-attendance, which may indicate a safeguarding issue. A letter was sent to parents when non-attendance occurred.

There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. There were weekly video conferences with social workers, health visitors and the community matron which included reviews of children, families and adults at risk. The safeguarding GP lead attended or contributed to case conferences as required. Practice staff had participated in the Identification and Referral to Improve Safety (IRIS) programme, a general practice-based domestic violence and abuse training support and referral programme.

There was a chaperone policy, which was visible on the waiting room noticeboard and was displayed in consulting rooms we visited. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We were told some reception staff occasionally acted as a chaperone if nursing staff were not available. All those acting as a chaperone had undergone training and a criminal records check and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Patients we spoke with who had used the chaperone service were happy with the process and the information on display about it.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Practice staff, were aware of the action to take in the event of a potential power failure or where required temperatures were exceeded. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

The practice nurses were not qualified as nurse prescribers, so patient group directions (PGDs) were in place in line with legal requirements and national guidance. PGDs allow specified health professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. All the necessary PGDs were signed as required and a folder was kept containing up to date directives. We saw, for example, two PGDs for 2014 covering combined vaccinations for protection against tetanus, diphtheria, and polio; and diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type B (five in one vaccine). We saw evidence that one of the nurses had received appropriate training and been assessed as competent to administer these medicines.

There was a policy in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. Regular reviews and medicines management plans were in place for those patients. There were a range of protocols to support appropriate medicines management including recall procedures for patients on anticoagulants and medicines for rheumatoid arthritis and mental health conditions.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms

were handled in accordance with national guidance as these were tracked through the practice and under the practice's prescription security profile were kept securely at all times.

Processes were in place to check medicines were within their expiry date and suitable for use and we saw the records for this. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. No controlled drugs were kept at the practice.

Cleanliness and infection control

We observed the premises to be clean and tidy and a comprehensive cleaning schedule was in place. Cleaning services were provided and managed by, the landlords of the practice premises. The surgery was cleaned every day. We checked the cleaning cupboard and saw a cleaning schedule was in place and all equipment was colour coded in accordance with relevant guidelines. The cleaners were managed by the landlords and signed in and out each day. There was book for the practice to record cleaning comments in. We checked the book and saw comments recorded and remedial action taken. Patients we spoke with raised no concerns about cleanliness or infection control.

The practice lead nurse and the lead partner GP were the lead staff for infection control. They had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received periodic updates. However, details were not available about the most recent training undertaken by several staff, including the majority of GPs. The most recent infection control audit completed in November 2014 identified that corrective action was necessary to ensure that all staff had regular 12 monthly updates on infection control. We were told arrangements were in hand for this.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There was appropriate personal protective equipment available to staff including disposable gloves, aprons and coverings. Spillage kits were also available and we saw records of where these had been used. Staff we spoke with were able to describe how they would use these to prevent the spread of infection. There was a process for internally recording and reporting untoward incidents in relation to infection prevention and control (including sharps injuries and body fluid splashes). Staff knew the procedure to follow in the event of such incidents.

To ensure good infection control practice, only use single use equipment such as specula, proctoscopes, needles, syringes was used. We saw the invoices from medical supplier for purchase of such equipment.

Regular infection control audits took place and the practice acted on the outcomes. For example, following the audit in November 2014 a new treatment couch was ordered to replace a damaged couch identified during the audit.

The landlords of the practice premises were responsible for the management, testing and investigation of Legionella (a germ found in the environment which can contaminate water systems in buildings). They contracted a specialist company to carry out regular Legionella checks. We saw the report of the latest survey completed in August 2014. The landlords were responsible for implementing the recommendations and action plan.

Clinical waste was stored appropriately and a contract was in place for its collection and disposal. Consignment notes were available for this and we saw a copy of the latest note dated 21 April 2015. Consignment notes were left with the practice manager after each collection of waste. They were then forwarded to the landlord who managed the contract on behalf of the building.

Equipment

Staff we spoke with told us they had 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. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was April 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment dated January 2015; for example weighing scales, spirometers, blood pressure measuring devices, nebulisers, defibrillator and pulse oximeters. We noted fire extinguishers needed re-inspecting by the end of April 2015. The practice manager was aware of this and in the process of arranging an inspection.

Good

Are services safe?

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The policy set out clear steps in the recruitment and interview selection process but the records of interview and selection decisions were not retained. The records we looked at of recently recruited staff, however, contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We spoke with a recently recruited member of staff who confirmed that the recruitment policy had been applied appropriately on their appointment. DBS checks had not been undertaken for the majority of administrative staff, apart from for those who occasionally acted as a chaperone. The practice manager had carried a risk assessment of not checking these staff and had determined that a check was not required based on their role and degree of unsupervised access to patients. However, the risk assessment had not been documented.

We were told that all staff received a comprehensive induction as part of the recruitment process. Staff we spoke with confirmed that they had followed an induction process and been provided with a clear job description which had been effective in helping them take on their new role.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. There was a contingency planning protocol to deal with short notice doctor sickness.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager told us that staffing levels were continuously reviewed to ensure staff numbers and skill mix were in line with planned staffing requirements. Growth in the patient list due to local demand had put pressure on the practice team and an assistant practice manager had been appointed to provide additional support and ease workloads. We saw that there was a good skill mix of GP staff with interests covering a range of areas including sexual health; cardiovascular disease (CVD); diabetes; chronic obstructive pulmonary disease (COPD); coronary heart disease (CHD); mental health; and palliative care.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice also had a combined health and safety policy and risk assessment. We saw the latest risk assessment of the practice completed on 13 October 2014. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice maintained close contact with mental health workers and there was a psychology mental health nurse and consultant on site to whom patients could be referred. They provided a psychological therapies service, including a range of treatments for anxiety and depression. The practice used the Q-Risk tool to assess patients' 10-year risk of developing cardiovascular disease (CVD).

There were arrangements to monitor high risk groups. For example, if a patient with a mental health problem did not attend appointments for hospital referrals the practice followed this up with the patient. Similarly, if children did not attend for appointments, the practice contacted the parent or guardian to find out the reason why.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed that the majority of staff had received training in basic life support and arrangements were in hand for those who had not. Emergency equipment was available including access to

Good

Are services safe?

oxygen, a pulse oximeter and an automated external defibrillator (used in cardiac emergencies). Staff we spoke with knew the location of this equipment. We saw that the equipment was operational and we reviewed the records which confirmed that it was checked regularly.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

An up to date disaster handling and recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This included loss of the surgery building, computer system, patient records, telephone and utilities, alarm systems and incapacity of staff. It also provided key staff and supplier contact numbers. In the event of major disruption to the service, the plan identified options for suitable alternative accommodation.

The practice carried out annual fire risk assessments and we saw the latest report dated January 2015 that included actions required to maintain fire safety. Records showed that there were regular fire alarm tests and fire evacuation drills carried out by the landlords of the premises. Staff received appropriate fire safety instruction during induction. Periodic update training had been provided for key staff but the practice had recognised that refresher training was needed for all staff as the most recent training for the majority of staff was completed in 2010 and for one member of staff in 2013.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told that new guidelines and alerts were disseminated by email and discussed at partner meetings, including the implications for the practice's performance and the action required for individual patients. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The GPs we spoke with told us they had special interests in a number of clinical areas including sexual health; cardiovascular disease (CVD); diabetes; chronic obstructive pulmonary disease (COPD); coronary heart disease (CHD); mental health; and palliative care. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines to support the effective assessment of patients' needs. To facilitate this, the practice held monthly tutorial meetings where clinical knowledge was shared. Outside speakers were on occasion invited to these meetings to speak on specific clinical areas.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, there were annual care plans in place for patients with mental health problems which included medical history; information on prescribed medication; and key actions. We saw evidence of such plans in reviewing patient records.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making. The practice kept registers of patients with learning disabilities and mental health problems to enable their care and treatment needs to be kept under review.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice provided a summary of its programme of audits completed in the last twelve months, including 12 clinical audits. These included two completed audit cycles where the practice was able to demonstrate improvement since the initial audit. For example, we reviewed an audit of patients offered sexually transmitted infections (STI) screening during consultations for emergency contraception. The first audit conducted over a three month period in 2014 found that a discussion regarding STI screening was documented in five of 13 consultations (38%), against target of 90%. As a result of the audit the practice decided to include 'sexual health screen offered' and 'emergency IUD offered' in the practice's contraception template, which was used when documenting emergency contraception consultations. In the second audit conducted over the next three months. The data showed a discussion regarding STI screening was documented in 9 of 18 consultations (50%). This was an improvement from the original audit but was still below the target of 90%. The audits were discussed within the practice and action included steps to further improve recording of discussion discussion regarding STI screening with a view to achieving the target rate.

This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 90.6% of the total QOF clinical target in 2014/15, which was slightly below the national average of 93.5%. This included the achievement of 100% for some of the QOF clinical targets, scoring above both the CCG and national average. For example:

- asthma related indicators, 3.3% above the CCG and 2.8% above the national average;
- atrial fibrillation related indicators, 0.4% above the CCG and 1.8% above the national average;
- depression related indicators, 10.4% above the CCG and 13.7% above the national average; and
- learning disability related indicators, 18.5% above the CCG and 15.9% above the national average.

Good

Are services effective?

(for example, treatment is effective)

There were, however, some areas where QOF achievement was below the CCG and national average, for example;

- diabetes related indicators, 14.2% below the CCG and 13.8% below the national average;
- heart failure related indicators, 3.3% below the CCG and 2.3% below the national average;
- hypertension related indicators, 27% below the CCG and 23.5% below the national average; and
- palliative care related indicators, 41.9% below the CCG and 46.7% below the national average.

The practice regularly reviewed QOF scores and had an action plan to secure improvements in lower scoring areas. We saw evidence of discussion of QOF in practice meeting minutes.

The practice had a safe and clear system in place for the prescribing and repeat prescribing of medicines, including a repeat prescribing policy. Prescriptions for patients taking regular medicines were accompanied by a computerised list of their medicines. Repeat prescriptions could be ordered on-line, by email, post, or in person at the practice. Patients were asked to allow at least 48 hours for repeat prescriptions to be processed before collection. Patients with repeat prescriptions were asked to see a doctor or nurse for a medication review at least annually to decide whether they should continue their medication. The medication of patients aged over 75 years and for those who were housebound was reviewed every six months. There was an alert on the practice's computer to identify when a review was due and a notification appeared on the patient's repeat prescription slip.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with learning disabilities and mental health problems. Structured annual reviews were also undertaken for patients with long term conditions, including diabetes, COPD, and heart failure.

The practice participated in local benchmarking run by the CCG through local and direct enhanced schemes (LES and DES). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. These included DES for dementia diagnosis, learning disabilities, avoiding unplanned admissions, and child vaccinations and immunisations. The practice attended two CCG GP Board Link peer to peer review meetings a year and four commissioning forums to discuss how the practice was performing against CCG averages and consider practice issues/hot topics. We saw the minutes of the December meeting and related data report which showed how practice activity related to the CCG operating plan and compared to other practices in areas such as A&E attendance, outpatient attendance, emergency admissions, health checks offered and immunisation. The minutes noted the impact on the practice of a the large increase in list size over the last three years including pressure on the staff and room capacity to manage the increasing list. The landlords had allocated two additional rooms to ease this pressure.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one having an additional diploma in child health, one in public health, sexual and reproductive health, and five with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

There were arrangements in place for staff to receive mandatory training and additional learning and development. We were provided with pre-inspection information about training completed by staff including child protection, medical emergencies and infection control. Update training had been provided in a number of areas. However, there were some gaps in recent training in infection control and fire safety. The practice manager told us the practice had been considering how best to secure mandatory training in these areas and more generally and arrangements were in hand for this. The practice had been in discussion with the CCG with a view to accessing their training services to meet the practice's needs.

There was an appraisal system for nursing and non-clinical staff which identified learning and development needs. We saw on staff records that appraisal reports had been completed and staff we spoke with confirmed they had received an appraisal. This included the opportunity to

Good

Are services effective?

(for example, treatment is effective)

discuss and agree their personal learning and development needs. Staff told us they found the appraisal process helpful and felt the practice was good at supporting training and allowing time to attend courses when needed. The practice manager told us that the majority of appraisals had been completed for the current reporting year but two were still to be carried out by the end of the year and arrangements were in hand for this.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, in administration of vaccines, asthma management and medical emergencies.

Administrative staff did not receive formal supervision but said they could speak to their manager for advice whenever they needed to and there were regular opportunities to discuss work matters at staff meetings. We saw from a sample of minutes of these meetings that issues such as staff cover for changes in duties, the appointment of new staff and the repeat prescriptions system had been reviewed.

The practice had policies and procedures for managing poor performance but we did not see any evidence that there had been a need to activate these recently.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Out-of hours reports, 111 reports and pathology results were all seen and usually actioned by a GP on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Discharge summaries and letters from outpatients were usually seen and actioned within 24-48 hours of receipt.

Emergency hospital admission rates for the practice were at 18.1% compared to the national average of 14.4%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Data on unplanned admission was regularly reviewed by the CCG for all practices in the locality. We saw in the practice action plan for the December 2014 CCG 'peer to peer review' meeting, the practice was required to give a detailed narrative review of the top two percent of patients who have unplanned admissions and attendances to identify areas where earlier intervention may be of benefit. The practice was also participating in the 'Test and Learn pilot for Integrated health and social care teams'. The expected outcome of the action plan was to reduce unplanned admissions and action on this was ongoing.

The practice held weekly video conference multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems (including dementia, people from vulnerable groups including elderly and frail patients and children and pregnant women on the at risk register. These meetings were attended by district nurses, health visitors, midwives, social workers, palliative care nurses and the community matron. There were quarterly meetings with the palliative care team to review patients with end of life care needs. We saw the minutes of the meeting in March 2015 when four patients were reviewed, which recorded that there were no reports of concerns of patients on the practice's palliative care list. The practice was putting in place care plans for patients with complex needs and shared these with other health and social care workers as appropriate. We saw an example of such a plan for a patient with mental health problems and another receiving palliative care.

The practice worked with a range of external professionals to review the needs of specific groups. For example, there were regular meetings with the Islington Crisis team who provided a rapid assessment of mental health crises and if necessary, a home treatment team provided an alternative to acute hospital admission. Patients from the practice were reviewed with the liaison person from the Crisis team. We saw the minutes of a meeting held in February 2015. The practice also worked closely with care navigators from charitable group who provided advice, information and access to support different groups and their carers including older people, people with dementia and people who had suffered a stroke.

The practice maintained close working relationships with a range of health and social care professional services based at the premises and regularly referred patients to them.

Good

Are services effective?

(for example, treatment is effective)

They included district nurses, a leg ulcer clinic, health visitors, psychiatric services, an anticoagulation clinic, retinal screening for diabetic patients, child psychologists, a dietician and citizens advice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. The practice used an electronic system for making referrals, the majority of which were made through the 'Choose and Book' system (a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had consent protocols for general consent, for the treatment of children and for the insertion of hormonal contraception. These protocols were understood and applied by staff. They confirmed they would always seek consent before giving any treatment and would make entries in patient records about consent decisions where appropriate. We saw that consent forms were available for use by clinical staff, for example for procedures that carried a degree of risk, for example cryotherapy treatment, or where for other reasons they considered it appropriate to do so. The protocols covered consent for children under the age of 16 and all clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The consent protocol did not make specific reference to the Mental Capacity Act 2005 with regard to mental capacity and "best interest" assessments in relation to consent.

However, guidance and in-house training had been provided to all staff regarding the Act and deprivation of liberty safeguards (DoLS) and we found staff were aware of the Act with regard to consent and best interest decisions.

Patients with a learning disability and mental health problems (including those with dementia) were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice nurse carried out physical health checks and gave health advice these patients. Ten of the 60 (17%) on the register had received a check in the last year. If any concerns were identified the nurse referred the patient to the patient's GP for further review.

Health promotion and prevention

There was a good range of information available to patients in the waiting area which included leaflets which could be taken away from the practice. There was also relevant health promotion information in the practice leaflet and on the practice website. The website included links to the NHS Choices Website, and the most popular health subjects, including sections on family health, long term conditions and minor illnesses.

The practice leaflet invited new patients registering with the practice to book an appointment for a health check. However, because of a large influx of new patients in the last year or so the check had not been routinely offered because the practice did not have the nurse capacity to do the check. New patients completed a comprehensive health information form which was entered on their patient record. If any health concerns were identified the GPs followed these up with the patient.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 189 eligible patients (6% in this age group) took up the offer of the health check. If any concerns were identified a follow appointment was arranged with the GP to carry out further investigations, including blood tests. Where appropriate patients were offered dietary and exercise advice and referred to a local exercise referral scheme, which provided supervised exercise sessions for people with a range of conditions including those with or at risk of coronary heart disease, diabetes, mild to moderate depression and

Good

Are services effective?

(for example, treatment is effective)

obesity. Obese patients could also be referred for bariatric surgery (an operation on the stomach and/or intestines that helps patients with extreme obesity to lose weight). We saw an example of such a referral in patient records we reviewed. The practice had bought a bariatric couch and scales for obese patients. All patients aged over 75 were offered an annual health check. Patients were asked to make an appointment with the practice nurses. If they were unable to attend the surgery the nurses could visit them at home.

There were also mechanisms in place to support health and wellbeing of particular patient groups in line with their needs. The practice participated in the Islington Stop Smoking local commissioned scheme (LCS) and had a number of trained smoking advisers who patients could see for support and advice. The practice had provided support to about a third of smokers identified and 86 of these (against an LCS target of 100) had quit smoking in the last 12 months. The practice provided a contraception, family planning and sexual health service. The practice offered screening for sexually transmitted diseases (STDs) which was carried out during appointments

The practice encouraged all women to attend for regular cervical smear testing. They were invited every three years between the ages of 25-49 and every five years from the ages of 50-64. The practice's performance for the cervical screening programme was 74%, which was below the national average of 82%. Reminders for patients who did not attend for their cervical screening test were made by letter and opportunistically during appointments. A practice nurse had responsibility for following up patients who did not attend. The practice had reviewed the below average rate of screening and was now accessing 'Open Exeter' (a database which GPs and other NHS organisations can access for a wide variety of patient data) to improve record keeping. The lead GP for smears had also been charged with meeting partner GPs and nurses to review the relatively low screening rates.

The practice also encouraged its patients to attend national screening programmes, including bowel cancer and mammography screening. Eighty of 278 eligible patients (18%) had attended bowel screening and 668 (61%) for mammography screening. There were arrangements in place to follow up when results were positive, for example a letter was sent to bowel screened patients for a colonoscopy.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was:

- Flu vaccination rates for the over 65s were 70%, and at risk groups 57%. These compared to national averages of 73% and 52% respectively.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 71% to 100% and five year olds from 78% to 99%. CCG and national comparative data was not available.

The practice routinely updated its computer records with immunisation information from other services and actively chased patients who did not respond to invitations to attend for immunisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014/15 and a survey of patients undertaken in February 2014 by the practice's patient participation group (PPG) (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were broadly satisfied with how they were treated and that this was with compassion, dignity and respect. For example, for satisfaction on consultations with doctors in the national patient survey:

- 85% said the GP was good at listening to them compared to the CCG average of 85% and national average of 89%;
- 79% said the GP gave them enough time compared to the CCG average of 81% and national average of 87%; and
- 92% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good or excellent service and staff were polite, efficient, helpful and caring. They said staff treated them with dignity and respect. The cleanliness of the premises was also praised. Two patients complimented the service but said waiting times could be lengthy and communication with health visitors could be improved. One patient was unhappy with their medication. We also spoke with 11 patients on the day of our inspection, including two members of the PPG. The majority told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Some comments were less positive for example about the appointment system and the promotion of on-line services.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private and we observed staff treating patients with great care and sensitivity. Staff told us they would take patients to a private area if necessary to maintain confidentiality.

The practice had a zero tolerance policy for abuse regarding any patient who is physically or verbally abusive or threatening towards staff or other patients. The policy was on display in the reception area and was stated on the practice website and in the practice leaflet made available to patients.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 87%; and
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and national average of 82%.

The responses to questions regarding nurses were also positive: For example:

- 91% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 90%; and
- 84% 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 of 85%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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

Good

Are services caring?

choice of treatment they wished to receive. One patient said there was no difficulty in getting an appointment but sometimes there was a long wait when they came to the surgery. Patient feedback on the comment cards we received was also mostly positive and aligned with these views.

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 patents this service was available. We saw also that the practice's website had a translation facility for each page in a wide choice of languages, and access to NHS fact sheets in different languages explaining the role of UK health services and the National Health Service (NHS), to newly-arrived individuals seeking asylum. We noted that there was an alert of patient records to identify that they might need language support during appointments. French was spoken by one of the practice team.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 88% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were mostly positive. For example, the majority of these highlighted that staff were supportive when they needed help. They felt safe, comfortable and well cared for by the whole practice team.

Notices in the patient waiting room, in the practice leaflet and on the patient website also 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 an 'Identifying carers protocol'. Information about patients identified as carers or who had carer entered in a patient's medical record. Clinical staff referred patients to social services or other appropriate services for assessment if problems were identified with carers, for example if a patient had no carer or the carer was unable to cope.

Staff told us there was a death notification protocol on the practice's computer system. If families had suffered a bereavement, their usual GP contacted them, offered their condolences and sent a 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. There was also bereavement advice on the practice's website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' healthcare needs and had systems in place to maintain the level of service provided. Patients we spoke with felt the practice met their healthcare needs, and in most respects they were happy with the care provided.

The practice engaged regularly with the local Clinical Commissioning Group (CCG) and other practices at locality meetings to discuss local needs and service improvements that needed to be prioritised. The CCG informed us that in 2014/15 the practice was signed up to 17 locally commissioned services (LCS). The CCG described the practice as one of the largest in the borough supporting a challenged community in terms of financial and social inequality. Doctors were involved in supporting the wider health economy, one as the CCG child safeguarding lead and another as medical director, integrated care, at Whittington Health.

The practice implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included improved phone access by upgrading the phone system to include an improved queuing system and an increased number of lines; quicker phone access by increasing the number of receptionists answering the phones, especially during the peak times; better promotion of on line services to make patients more aware of alternative ways to book appointments and request repeat prescriptions; and better access to the service by the take on a new partner to meet an increase in patient list size. The Practice had also been approved as a training practice and started to take on registrars from Summer 2014, making more clinical appointments available.

The practice aimed to offer continuity of care and accessibility to appointments with a GP of choice for routine appointments, but acknowledged this was a challenge when set against the need to provide urgent appointments. In the national patient survey 2014/15 the practice scored 43% for patients with a preferred GP who usually get to see or speak to that GP. This was 10% below the CCG and 18% below the national average. However, the practice viewed continuity as a priority and had adopted an 'all partner GP model' to provide improved peer review and secure improved long term care. Patients could have an appointment with a named GP but that might involve a slight delay. The average wait time for named GP would be a 3-4 days. If there was no specific request for a named GP, they would be seen on the day. Most of these would be handled by the duty doctor who would deal with telephone calls and then decide who needed to come in and see a GP. The practice had two male and seven female GPs, so was able to offer choice of male or female doctor if this was requested.

Each patient over 75 had a named GP. Their care was reviewed regularly at multidisciplinary team meetings. Over 75 health checks offered by the practice nurse with the option of home visits to carry out these checks. GPs visited local sheltered accommodation and hostels to provide flu immunisations. Blood tests were carried out at the practice but could also be done at home for housebound patients. Doctors also did urgent bloods and ECG tests at home for these patients. Patients visiting the older people's charity day centre next door to the practice were seen by clinical staff on the day if requested by day centre staff. Memory assessments were carried out under dementia screening and patients were referred to a local memory clinic if appropriate.

The practice ran an antenatal clinic and appointments could be booked with any of the doctors. There was a weekly child health clinic and a walk in service for mothers who wished to speak with a health visitor (based at the premises) or wanted their baby weighed. Invites for the maternal post natal check and six week baby check appointment were sent out on receipt of the maternity discharge from hospital. The appointment was booked with the patient's usual doctor to provide continuity. All GPs in the practice did these checks so they did not become de-skilled. The check was offered at the end of morning surgery to allow for extra time if needed. Non-attenders were called and recalled if necessary. If they still did not attend their usual doctor and child protection lead, were informed in case of a safeguarding issue. First baby immunisation appointment invites were automatically sent out and followed up by telephone by the nurse if the mother didn't attend.

A duty doctor was available daily to triage patients between 8:30am and 6:30pm via the telephone but if

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients walked in with urgent conditions or were frail the practice would fit an appointment in. Sick children were prioritised and children under one year were fitted in for an appointment if they were brought to the surgery.

There were clinics for cryotherapy treatment, diabetic checks; family planning and emergency contraception; and travel advice and vaccination. The practice provided 'catch up clinics' for immunisations for teenagers and students. Nurse-led reviews were offered for asthma, COPD, stable diabetes, blood pressure and heart disease. There were two blood pressure pods in the waiting area to enable patients to self-check blood pressure.

The practice maintained close contact with mental health workers and there was a psychology mental health nurse and consultant on site. Patients had access to an on-site drug/alcohol dependence nurse weekly and the lead partner met the nurse weekly to review cases. One of the practice nurses was mental health trained and contacted all patients on the mental health register to arrange an annual appointment for health promotion and blood checks. The nurse also visited a local homeless charity to carry out health checks on residents.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, double appointments were offered to patients that needed them. After the patient had been seen they were given a slip by the GP and told to go to reception to make the follow up appointment. The slip of paper also stated whether a double appointment was needed.

The practice staff had ready access to a telephone translation services and a member of staff spoke French.

The practice had an equal opportunities and discrimination policy. Staff were made aware of the policy as part of the induction process and staff we spoke with understood patients' equality and diversity needs covering a diverse population of patients. However, only a small number of staff had received specific equality and diversity training.

The premises and services had been adapted to meet the needs of patient with disabilities. The surgery had suitable access for wheelchair users and people with other mobility difficulties. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice also had an induction loop for patients with hearing difficulties and made special arrangements for patients who were visually impaired or had other disabilities. There was for example a large print version of the practice leaflet available.

Under the practice's registration policy the practice had an 'open door' policy and all new patients were welcomed provided they lived in the practice's catchment area. Patients with no fixed abode could use the practice address to register. Two homeless people were registered with the practice at the time of the inspection.

Access to the service

The surgery was open and appointments were available from 8:30am to 1:00pm and from 2:00pm to 6.30pm on Monday to Friday. There was also a Saturday morning surgery from 9:00am to 1:00pm and one early morning surgery a week from 7:20am to 8:00 am. Both of these clinics were for pre-bookable appointments only. A duty doctor was in the practice until 6:30pm Monday to Friday. The practice offered 10 minute appointments, pre-booked, same day appointments and appointments bookable four weeks in advance. Same day appointments were released at 8.30am and 2.00pm each day. The duty doctor provided 17 face to face appointments and three telephone consultations each day. Of the 12,600 or so patients registered only 700 had registered for on-line booking of appointments and the practice recognised the need to promote this service more widely to patients. Text reminders were sent to patients the day before an appointment. The 'did not attend' (DNA) rate for the practice was less than 3% for which the practice partners felt some pride.

Comprehensive information was available to patients about appointments in the practice leaflet and on the website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours services were provided by a local provider. Access to the service was via the national NHS 111 call line. The NHS 111 team would assess the patient's condition over the phone and if it was clinically appropriate, would refer the case to the out of hours service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The majority of patients we spoke with and received comments cards were happy with the appointments system. One patient said telephone consultations did not work well from their perspective and two mentioned that waiting times can be lengthy. Comments received from patients showed that patients in urgent need of treatment were usually able to make appointments on the same day of contacting the practice.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 73% were satisfied with the practice's opening hours compared to the CCG average of 67% and national average of 76%;
- 86% described their experience of making an appointment as good compared to the CCG average of 69% and national average of 74;
- 76% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 61% and national average of 63%; and
- 89% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 74%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. The practice manager was the complaints manager and a nominated GP partner led on clinical complaints. The complaints procedure, dated October 2014, explained how patients could pursue matters further with NHS England if they were dissatisfied with the handling of their complaint. There was guidance to reception staff on handling complaints with advice to refer the matter to the practice manager, senior receptionist, partner or duty doctor if the matter needed to be escalated.

We saw that information was available to help patients understand the complaints system. Details were available in the reception area and there was a patients' complaints leaflet and form which were offered to patients if they wished to make a complaint. There was also information about making complaints in the practice leaflet and on the practice website. Patients we spoke with were not all aware of the complaints procedure but the majority said they had not needed to make a complaint about the practice.

We looked at 12 complaints received in the last year which included a summary of the complaint, the GP involved, the action taken and lessons learned. We saw that these were dealt with in a timely manner. The letter of response offered an appropriate explanation and apology.

Staff we spoke with were generally aware that patients could complain about the service and were aware of the complaints procedure document. We were told that learning from complaints was discussed within the practice and the practice's analysis of complaints recorded a number of instances where discussions had taken place, for example in relation to a complaint about a misunderstanding relating to a diagnostic test where the member of staff was reminded when dealing with patients to communicate more clearly to avoid misunderstandings. We also saw evidence of discussion of complaints and lessons learned in the minutes of meetings we reviewed and complaints were included on the agenda when cases arose.

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 ethos which involved putting patients first and was committed to providing them with the best possible service. Underpinning this, the practice followed standards set by external health agencies including the local CCG and NHS England. The practice's mission statement which was displayed on the practice website set out the overall aims of the practice to offer: continuity of care and timely access to reliable health advice; effective treatment delivered by trusted professionals; to encourage participation in decisions and have respect for patients' preferences; pay attention to physical and environmental needs; and offer emotional support, empathy and respect. It also gave a commitment to encourage the involvement of and support for family and carers; provide clear, understandable information and support for self-care; and to take confidentiality very seriously. Not all staff we spoke with were aware of the mission statement. However, all staff were able to articulate the essence of the practice ethos and it was clear that patients were at the heart of the service they provided.

Governance arrangements

The practice had a comprehensive range of policies and procedures in place to govern activity and these were available to staff via the computer system within the practice. There were appropriate human resource policies. Separate clinical practice policies and procedures including policies on consent, infection control and chaperoning, were also accessible to all staff. The policies were subject to regular review and updating and all the policies we looked at had been reviewed in the last year.

There was a clear leadership structure with named members of staff in lead roles. For example, there were named GP leads for safeguarding, infection control, medicines management, and clinical governance. We spoke with 11 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF data showed the practice performed above other practices in the local CCG area about two thirds of the indicators in the year ending April 2014 and in many of them scored 100%. QOF data was regularly discussed at clinical team meetings and action planning put in place to maintain or improve outcomes. Individual GPs were designated leads for different aspects of QOF performance.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, a repeat audit of patients offered sexually transmitted infections (STI) screening during consultations for emergency contraception and another on patients on oral bisphosphonates (used for the treatment of patients with osteoporosis – brittle bones). Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice had arrangements for identifying, recording and managing risks. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The practice regularly monitored and reviewed risks to individual patients, using specific risk assessment and management tools where appropriate, and updated patient records accordingly. Health and safety and fire risk assessments had been completed in October 2014 and January 2015 respectively and the action plans implemented.

The practice held weekly meetings with practice manager/ assistant practice manager; a weekly meeting with the lead nurse and monthly all nurses/Health Care Assistant meetings; partner meetings weekly, two monthly evening meetings and a GP away day. There were meetings of the reception team every month which were attended by one of the GP team. We looked at minutes from a sample of these meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that staff meetings were held regularly, at least 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. Staff felt that the practice worked well as a team and provided mutual support. Staff felt that communication within the practice was generally good,

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The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment policy, induction policy, and equal opportunity and discrimination, which were in place to support staff. We were shown a range of policies governing staffing issues that were available to all staff, which included, bullying and harassment; confidentiality, stress and responding to abusive patients. Staff we spoke with knew where to find these policies if required

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys NHS friends and family test and complaints received. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The PPG aimed to meet two to three times a year and also corresponded by email between meetings. The practice continued to advertise PPG meetings through a variety of methods but recognised numbers attending the meetings were still variable. There was a core group of around six patients and others who occasionally attend. The practice was focused on attracting more members. There was a dedicated Patient Group notice board in the main waiting area which displayed the dates of forthcoming meetings both for the practice and for the meetings of the wider Islington Patient Participation Group.

The PPG carried out annual surveys and we were shown the action plan arising from the last patient survey, conducted in 2013/14 which was considered in conjunction with the PPG and reported in the group's annual report. With PPG agreement the latest survey concentrated on how long patients had

to wait to get through to the practice on the phone, waiting time at the surgery and if they were

satisfied with the appointments they got. We were shown the action plan in response to the survey which had been implemented to make a range of improvements to access to appointments.

We spoke with two members of the PPG. While they were generally positive about the role the PPG played and felt engaged with the practice, they told us they would like to increase membership to include a more diverse range of patient representation. They felt that more could be done to advertise the activities of the group, to attract volunteers. They felt also the PPG should meet at least twice a year in line with the originally aims rather than annually as at present. An open day had been planned for this purpose but had not taken place due to pressures as a result of a sudden large influx of new patients during the year and staff sickness. The PPG members were complimentary about the responsiveness of the practice to feedback provide through the group such as the upgrade of the website and the introduction of telephone appointments. We noted that on the practice's website patients were invited to join the group by completing an on line form or by printing a copy of the form and bringing it completed to the practice. Patients could also sign up for email communications from the PPG. We saw that there was a dedicated PPG notice board in the reception area which provided a good range of information about the group and its activities.

In the latest NHS friends and family test 96% of 51 patients who responded recommended the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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 in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy. Staff we spoke with were aware of the policy and knew who to go to if they wished to report any concerns.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and saw that they received regular appraisals and learning and development needs were linked to the appraisal process.

The practice was a GP training practice and had one GP Registrar trainee working at the practice at the time of the inspection. We spoke with the Registrar who felt they received effective developmental support and supervision.

The practice had completed reviews of significant events and other incidents which included lessons learned. Staff we spoke with confirmed that the outcomes of significant events were discussed with them and we saw evidence of this in practice meetings minutes. For example, we saw

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discussion of a case of a child safeguarding incident and another where staff had felt threatened by a patient's behaviour. Lessons learned and resulting action were identified in both cases.