The Northern Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Northern Medical Centre on 14 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, people experiencing poor mental health (including people with dementia) and for people with long term conditions. It was rated as requires improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned. For example, although non clinical staff had not received children and vulnerable adults safeguarding training, we noted that this was scheduled to take place by August 2015.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider must:

- Introduce a documented system for checking expiry dates of emergency medicines.
- Ensure that clinical waste awaiting collection is stored away from patient areas and introduce a clinical waste storage policy.
- Ensure that cleaning schedules are introduced for ear syringe, nebuliser and spirometer equipment.

In addition the provider should

- Ensure that non clinical staff undertake children and vulnerable adults safeguarding training
- Review its significant events procedures to ensure learning is shared with non clinical staff.
- Ensure routine minuting of weekly partner and clinical meetings; to enable reflection on outcomes being achieved and to identity improvement areas.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses (including safeguarding concerns). Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients and staff were assessed and well managed (for example infection prevention and control audits). There were enough staff to keep people safe. Lessons were learned and communicated to support improvement; although sharing learning from significant events did not include non clinical staff. Emergency drugs were within expiry date but a formal system for checking and recording dates was not in place. Non clinical staff had not undertaken safeguarding training although we were advised that this would take place by August 2015. Clinical waste was not stored securely and safely away from patient areas, whilst awaiting collection.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with Islington Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments

Summary of findings

available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice had a number of policies and procedures to govern activity and held regular governance meetings although these were not always minuted.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and weekly nursing home visits (including rapid access appointments for those with enhanced needs).

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and longer appointments and home visits were available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Non clinical staff had not received safeguarding training. The practice had a policy in place to ensure that homeless patients were treated with dignity and respect when they registered.

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 regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

During our inspection, we spoke with four patients including a PPG member. They spoke positively about patient care and about how the practice listened and acted on the group's concerns.

We also reviewed 31 CQC patient comment cards. These had been completed by patients in the two week period before our inspection and enabled patients to share with us their experience of the practice. Feedback was positive with key themes being that staff were respectful, that they listened and that they were compassionate. The patient profile ranged from newly registered patients to those who had been with the practice for more than ten years.

We also used existing patient feedback to guide our discussions with patients. For example, the NHS England National GP Patient Survey 2014 (460 surveys sent out, 117 returned, 25% response rate) highlighted that 84% of respondents said that the last GP they saw or spoke to was good at giving them enough time and that 87% of respondents said that the last nurse they saw or spoke to was good at treating them with care and concern. This was consistent with patient feedback on the day of our inspection and with comment card feedback. The national survey also highlighted that only 66% of respondents found it easy to get through to the surgery by phone compared with the local CCG average of 76%. This was consistent with patient feedback on the day (although the practice outlined how it had responded to this issue). None of the comment cards we looked at identified phone access as an area of concern.

Areas for improvement

Action the service MUST take to improve

- Introduce a documented system for checking expiry dates of emergency medicines.
- Ensure that clinical waste awaiting collection is stored away from patient areas and introduce a clinical waste storage policy.
- Ensure that cleaning schedules are introduced for ear syringe, nebuliser and spirometer equipment.

Action the service SHOULD take to improve

- Ensure that non clinical staff undertake children and vulnerable adults safeguarding training
- Review its significant events procedures to ensure learning is shared with non clinical staff.
- Ensure routine minuting of weekly partner and clinical meetings; to enable reflection on outcomes being achieved and to identity improvement areas.

The Northern Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, practice nurse specialist advisor and practice manager specialist advisor; granted the same authority to enter the registered person's premises as the CQC lead inspector.

Background to The Northern Medical Centre

The Northern Medical Centre is located in Islington, North London. The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities. The practice has opted out of providing out-of-hours services to their own patients.

The practice has a patient list of approximately 8,800. Approximately 8% of patients are aged 65 or older and approximately 24% are under 18 years old. Fifty one percent have a long standing health condition and 11% have carer responsibilities.

The surgery is open from 8:30am to 6.30pm Monday, Tuesday, Wednesday and Friday (including through lunch), Thursday 8:30am-1.00pm and Saturday 09.30am-1.00pm. Appointments are available from 09:30-12.30pm and 3pm to 6.20pm on weekdays; and 09.30am to 1.00pm on Saturdays.

When the practice was closed (including from 8:00am to 8:30am Monday to Friday and from 1pm to 6.30pm on Thursdays) patients were referred to an out-of-hours service provider.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice and management of long term conditions clinics. The staff team comprises four GP partners (three female, one male), two salaried GPs (one male, one female), two female practice nurses, practice manager and a range of administrative staff.

The practice is registered with the Care Quality Commission to carry on the regulated activities of Treatment of disease, disorder or injury, Diagnostic and screening procedures, maternity and midwifery procedures and surgical procedures.

Why we carried out this inspection

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

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:

Detailed findings

- 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 living in vulnerable circumstances
- 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 carried out an announced visit on 14 April 2015. During our visit we spoke with a range of staff (GPs, practice nurse, practice manager and reception staff) and spoke with patients who used the service including a PPG member. We observed how people were being cared for and talked with carers and/or family members. We also reviewed 31 comment cards where patients shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice prioritised safety and 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.

Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, following an incident where there had been difficulties locating emergency drugs for a patient experiencing a sudden allergic reaction, the practice had centrally relocated its emergency drugs and also introduced clearer labelling.

We reviewed safety records and incident reports where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over this period.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred during the last 12 months and saw this system was followed appropriately. There was evidence that the practice had learned from these events although there was no written evidence that findings were shared with administrative staff.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked two incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, one significant event related to a recently registered nursing home patient who was nearing end of life but whose next of kin had not been advised because their details were not on file. The next of kin were therefore unable to be with the patient when they died. Following this incident, the practice introduced additional checks to ensure that next of kin details were recorded for all nursing home patients.

National patient safety alerts were disseminated by the practice manager to practice staff. They gave examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all GPs had received relevant role specific training on safeguarding. However, non clinical staff had not received safeguarding training. We were told that this would take place by October 2015.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. All staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. 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 that only clinicians undertook chaperoning duties. Records showed that they had received Disclosure and Barring Service (DBS) checks.

Requires improvement

Are services safe?

DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records that noted the actions required in response to a review of prescribing data. They showed how senior GPs used prescribing audit data to improve medicines management at the practice (for example using the audit results to promote the use of cheaper, generic medicines).

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. These had been updated in 2014. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

We looked at emergency medicines and saw that they were within their expiry date. The practice had a system in place to check that drugs were in date but this was not recorded and we therefore could not be assured that regular checks were taking place.

After our inspection we were sent evidence confirming that the practice had introduced a system of regular checks and a written policy for checking emergency medicines.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, a reception staff members' description of how they received patient specimens was consistent with the practice's specimen handling policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The two practice nurses led on infection and prevention control at the practice. One of the nurses had undertaken further training to enable them to provide advice on the practice's infection control policy and carry out staff training. We saw evidence that the practice had carried out an infection control audit within the last twelve months and that any improvements identified for action were completed on time.

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. The practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

A contract was in place with the NHS landlord of the building and an external contractor for weekly collection of clinical waste. However, there was no facility for securely storing clinical waste away from patient areas which meant that clinical waste could potentially await collection in clinical waste bins in treatment rooms for up to one week. We were advised that the practice would look into this issue with its NHS landlord. We noted that the practice did not have a clinical waste disposal policy.

After our inspection we were sent a copy of the practice's new Clinical Waste Disposal Policy. We were also advised

that the practice had amended its procedures so that clinical waste bins located in the clinician's rooms were emptied at the end of each day and stored securely away from patient areas whilst awaiting collection.

We also noted that the practice did not have cleaning schedules in place for its ear syringe, nebuliser and spirometer equipment.

After our inspection, we were sent copies of the practice's new protocols for cleaning ear syringe, nebuliser and spirometer equipment. We were also told that the practice had changed ear syringe appointments to one dedicated day per week to allow for the equipment to be adequately cleaned at the beginning and end of the day.

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 had been within the last twelve months. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometer and blood pressure measuring devices within the last twelve months.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at 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 the appropriate checks through the Disclosure and Barring Service. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

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 rota 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. Newly appointed staff had this expectation written in their contracts.

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 showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring Safety & 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, staffing and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Clinical meeting minutes and partner meeting minutes showed some evidence of risks being assessed and rated and of mitigating actions being taken to reduce risk as necessary. However, we noted that these meetings were not regularly recorded.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Significant events records showed that the practice had learned from an incident whereby staff had had difficulty locating medical emergency drugs.

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 (a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar). All the medicines we checked were in date and fit for use and the practice had a system in place to check that drugs were in date. However, this was not recorded and we therefore could not be assured that regular checks were taking place.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Requires improvement

Are services safe?

the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk risks identified including power failure, adverse weather and unplanned sickness. The document contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. However, we noted that the plan did not include arrangements in the eventuality that the building could not be used.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 discussed with the practice manager, a GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and were in line with these 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, patients with diabetes had regular health checks and were referred to other services when required. Feedback from patients confirmed they were promptly referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. 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 review and discuss new best practice guidelines, for example, cardio vascular disease prevention. We were able to confirm that guidelines had been shared by email but there was no evidence of discussion at clinical meetings.

Interviews with GPs and a practice nurse showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the past two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit in 2012.

One of the completed audits was triggered by NICE screening guidelines on the care of patients with gestational diabetes: a condition affecting pregnant women and which increases the likelihood of developing diabetes in later life. The first stage of the audit identified that 78% of patients identified with gestational diabetes had been screened within three months of child birth but that none had been offered post natal dietary advice, weight management or exercise advice. The audit recommended that screening and advice systems be improved and when the re-audit took place in 2013, dietary advice take up had increased from zero to 71%.

The practice had achieved 97% of the total QOF target for the latest available period in 2013/14 which was 3.3% above the CCG average and 3.8% above the national average. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. Clinical indicators where the practice had maximised their QOF points in 2013/14 included asthma, cancer and lung disease (also known as chronic obstructive pulmonary disease -COPD). The practice was aware of areas of QOF under performance. For example, the clinical meeting minutes that were available highlighted the need to improve diabetic care performance.

The practice's prescribing rates were similar to national figures. For example the prescribing of antibiotics, hypnotic and anti-inflammatory drugs were in line with the national average. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health

Good

Are services effective?

(for example, treatment is effective)

checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. Benchmarking data showed the practice had outcomes that were slightly worse comparable to other services in the area regarding prescribing. We also saw evidence that the practice was taking action to improve its performance in this area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date regarding mandatory courses such as basic life support and infection control. Non clinical staff had not undertaken safeguarding training. We were advised that this would take place by August 2015.

We noted a good skill mix among the doctors with GPs having qualifications in minor surgery, coils and implants, and joint injections. 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 had been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.)

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, the practice had provided customer service training for its practice manager which had been cascaded to reception staff.

The practice nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example they had received training and updates in mental health awareness, cervical cytology, phlebotomy and wound care. However, nurses had not undertaken in depth training in long term conditions such as diabetes, COPD or asthma.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for conditions such as diabetes, COPD and asthma were relatively low compared to the CCG and national averages. The practice was commissioned for the unplanned admissions enhanced service (these require an enhanced level of service provision above what is normally required under the core GP contract). However, we noted that the practice's clinical system did not alert clinicians to when patients were discharged from hospital. The practice told us that they would look into amending their clinical system.

The practice held monthly multidisciplinary team meetings to discuss patients with complex needs such as patients experiencing poor mental health, long term conditions or with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. Staff generally felt this system worked well.

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.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by August 2015. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff (for example, with making do not attempt resuscitation orders). The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Records showed that a significant event incident concerning end of life care for a nursing home patient had resulted in improvements to how the practice involved families and career where patients lacked capacity. 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 practice had not needed to use restraint but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The patient's GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 35 to 75 years. Practice data showed that 36% of patients in this age group took up the offer of the health check. We were shown the process for following up patients within 48 hours if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 93% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to 1% of these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was 9 (comparable local and national data was unavailable). Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Latest available comparable performance for the cervical screening programme was 70.9%, which was below the national average of 77%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend

Good

Are services effective?

(for example, treatment is effective)

and text messaging was also used. The practice encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. There were similar systems in place for non attending patients.

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 above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s was 77% (which was above the national average).
- Childhood immunisation rates for vaccinations given at twelve months, twenty four months were generally at 90% or above (comparable national data was unavailable).

We noted that the reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and patient satisfaction questionnaires sent out to patients by each of the practice's partners.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the National GP Patient Survey showed that the practice performed better than the CCG average regarding the extent to which GPs were good at giving enough time (84% compared to 80%) and the extent to which the nurse was good at treating patients with care and concern (87% compared to 84%). Practice performance was also better than the CCG average regarding the extent to which respondents felt nurses were good at giving them enough time (90% compared to 88%).

Patients were positive about how they were treated by reception staff and during our inspection we observed that reception staff treated patients with dignity and respect. When we spoke with a receptionist they stressed the importance of seeing a patient as an individual. Patients spoke positively about how they were treated by GPs and nurses and we noted that this was also consistent with CQC comment card feedback.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards all of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. They were satisfied with the care provided by the practice and said their dignity and privacy were respected.

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. Privacy was not highlighted as a concern in any of the 31 comment cards we reviewed.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations. We noted that their polite and respectful manner was useful when seeking to help patients whose behaviour challenged the service.

Care planning and involvement in decisions about care and treatment

Patient survey feedback was positive regarding questions about patients' involvement in planning and making decisions about care and treatment. For example:

- 82% said the last GP they saw was good at explaining tests and treatments (compared to the CCG average of 83% and national average of 89%).
- 76% said the last GP they saw was good at involving them in decisions about their care (same as CCG average but lower than the 81% national average).

Patients confirmed that they felt involved in decisions about their care and treatment. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about their choice of treatment. Comment card feedback was also 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 including British Sign Language. We saw notices in the reception areas informing patients this service was available.

The practice website and reception contained a range of information to help patients make informed decisions about their care and treatment (for example managing a long term condition).

Good

Are services caring?

A receptionist described the steps that he and colleagues routinely undertook to help patients who needed additional support, understand and be involved in their care.

Patient/carer support to cope emotionally with care and treatment

National patient survey feedback was also positive about the emotional support provided by the practice and rated it well in this area. For example:

- 87% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 90%.
- 83% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 85%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. They highlighted that staff responded compassionately when patients needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. We noted that 11% of patients had a caring responsibility and we were told that the practice routinely signposted patients to a local carer support network. Information was also available in the practice reception, on the practice website and in patient participation group leaflets. The practice's computer system also alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. 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.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, we were told that the practice had run a prevalence exercise and identified twenty new patients in response to recent CCG data highlighting that coronary heart disease prevalence was below expected.

The practice regularly engaged with Islington CCG to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where actions had been agreed to implement service improvements to better meet the needs of its population. For example, records showed that a recent meeting had sought to improve web based clinical access for GPs on their weekly nursing homes visits.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

For example, the group had highlighted appointments access as a priority area when two of the then three partners had gone on long term sick leave and maternity leave. In response, we were told that the practice had appointed a fourth partner and employed two salaried GPs. Patient feedback on the day and comment card feedback was positive regarding appointments access; although we noted that this was highlighted as a concern in the 2014 national GP survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and the practice provided interpreters for non English speakers including British Sign Language.

The majority of the practice population were English speaking patients but access to online and telephone interpreting services were available if they were needed. A hearing loop was installed in reception. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. The practice clinical system had alerts on the notes of patients with sensory impairments so that all staff were able to assist them within the practice.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were accessible by lift. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with space for wheelchairs and pushchairs to easily manoeuvre. This made movement around the practice easier and helped to maintain patients' independence.

The practice had a policy in place to ensure that homeless patients were treated with dignity and respect when they registered. There was also system for flagging vulnerability in individual patient records. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Records showed that staff had not attended equality and diversity training. However, staff we spoke with demonstrated an understanding of equality diversity principles; such as treating patients as individuals.

Access to the service

The surgery is open from 8:30am to 6.30pm Monday, Tuesday, Wednesday and Friday (including through lunch), Thursday 8:30am-1.00pm and Saturday 09.30am-1.00pm. Appointments are available from 09:30-12.30pm and 3pm to 6.20pm on weekdays; and 09.30am to 1.00pm on Saturdays.

When the practice was closed (including from 8:00am to 8:30am Monday to Friday and from 1pm to 6.30pm on Thursdays) patients were referred to an out-of-hours service provider.

Comprehensive information was available to patients about appointments on the practice 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. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Home visits and longer appointments were available where needed for older people and patients with long-term conditions. Appointments were available outside of school hours for children and young people. Extended opening hours, telephone consultations, online booking, text message appointment reminders were particular responsive to working aged people. The practice offered flexible services and appointments; for example, avoiding booking appointments at busy times for people who may find this stressful. Longer appointments were offered for people experiencing poor mental health.

Home visits were made to two local care homes on a specific day each week, by a named GP and to those patients who needed one.

However, patient survey feedback was not positive regarding access to appointments. For example:

63% were satisfied with the practice's opening hours compared to the CCG average of 67% and national average of 75%.

- 65% described their experience of making an appointment as good compared to the CCG average of 69% and national average of 73%.
- 66% said they could get through easily to the surgery by phone compared to the CCG average of 76% and national average of 73%.

We spoke with four patients; two of whom expressed concerns regarding phone appointments access. However, all four patients told us that they could see a doctor on the same day if they felt their need was urgent (although this might not be their GP of choice). Comment card feedback was generally positive regarding the appointments system.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available in the practice reception, on its website and in its patient leaflet to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

Record showed that nineteen complaints had been received in the last twelve months. We looked at four complaints and found that these were satisfactorily handled and dealt with in a timely way in accordance with the practice's complaints policy. However, there was no evidence of an analysis of complaints received or of how learning from complaints had been used to improve the service.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We did not see evidence of a business plan but discussions with staff and review of available partner and clinical meeting minutes highlighted that the practice's focus was upon good quality patient centred care and treatment.

We spoke with seven members of staff who understood the practice's vision and values and their role in in relation to these vision and values.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at ten of these policies and procedures. Although there was no system in place to confirm that staff had read the policy, they demonstrated an understanding. All ten policies and procedures we looked at had been reviewed in the last twelve months.

There was a clear leadership structure with named members of staff in lead roles. For example, there were lead staff members for infection control and safeguarding. Staff were 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 partner GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the QOF data to measure its performance. QOF data for this practice showed it was performing in line or better than national standards. We noted that minute taking of weekly clinical meetings was infrequent and there was therefore limited evidence of how QOF data was used to maintain or improve patient outcomes.

The practice explained that for much of 2014, two of the three GP partners had been on maternity leave and long term sick leave. However, we were further advised that a fourth GP partner and two salaried GPs had been appointed and that weekly, minuted clinical meetings would take place.

After our inspection we were advised that practice and staff meetings were now also being minuted, following the appointment of a new practice manager.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example a recent audit had looked at how care could be improved for patients with atrial fibrillation; a heart condition that causes an irregular and often abnormally fast heart rate. Additionally, there were processes in place to ensure that action had been taken, when appropriate, in response to feedback from patients. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented (for example an infection control audit and associated action plan had taken place within the last twelve months).

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies (such as induction and management of sickness policy) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. We were told that all staff were involved in discussions about how to run the practice and how to develop the practice.

Staff told us that there was an open culture within the practice and they had the opportunity and felt confident to raise any issues at bi monthly team meetings. However, we noted that these meetings were not minuted. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Are services well-led?

Good

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

Practice seeks and acts on feedback from users, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients complaints received. It had an active PPG which included representatives from various groups including older people and patients with long term conditions. However, the PPG only met every six months and had not undertaken a patient survey in the last twelve months. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. We also saw evidence that the practice had responded to feedback left on the NHS Choices website. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

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.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at two staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. However, there was no evidence of how this was shared with non clinical staff. After our inspection we were advised that learning from significant events was now routinely shared with non-clinical staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Suitable arrangements were not in place to check expiry dates of emergency medicines. Regulation 12(2)(g) Suitable arrangements were not in place for the safe storage of clinical waste away from patient areas; whilst awaiting collection. Regulation 12 (2)(h) The practice did not have cleaning schedules in place for its ear syringe, nebuliser and spirometer equipment. Regulation 12 (2)(h)