The Vale 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 Vale Practice on 8 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring, safe 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.

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, with the exception of those relating to recruitment checks.
- 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.
- Patients said they were treated with compassion, dignity and respect; and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses (including safeguarding concerns). Lessons were learned and communicated widely to support improvement. 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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data we looked at before our inspection showed that patient outcomes were at or above average for the locality regarding childhood immunisations and uptake of seasonal flu vaccine for patients aged 65 and older.

Peoples' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams and used guidance from the National Institute for Health and Care Excellence (NICE) to improve patient outcomes. We saw evidence that clinical audits were being used to help improve patient outcomes (for example regarding diabetic care).

Are services caring?

Good

The practice is rated as good for providing caring services. Patient satisfaction (in terms of whether patients would recommend the practice) was higher than other Haringey practices. Feedback was also positive regarding the helpfulness of reception staff and patients' involvement in decisions about their care. People told us they were treated with compassion, dignity and respect. They also told us that the doctors and nurse provided sufficient information to be able to make informed decisions about their care and treatment. We saw that staff treated patients with kindness and respect and maintained confidentiality. We noted that the practice reception desk and waiting room were in close proximity but patients told us that staff always ensured that patient privacy and confidentiality were maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had good physical facilities such as wheelchair access and

Summary of findings

baby changing facilities. It was also well equipped to treat patients and meet their needs although we noted that space in the reception area was limited. Longer appointments were offered for those that needed them and we saw that language interpreting (including British Sign Language) was available.

Urgent same day appointments were available but not usually with a named GP. The practice worked with ten other local practices to provide Saturday morning clinics. Patients told us that this was in response to their request for improved access. Information about how to complain was available and easy to understand. We also saw evidence that the practice learned from complaints and used this information to improve the service.

Are services well-led?

Good

The practice is rated as good for being well-led. There was clear leadership and staff told us they felt supported by management. The practice also had a clear vision and staff explained how their roles and responsibilities contributed to this vision.

The practice had a number of policies and procedures to govern activity and we noted that the GP partners undertook lead roles such as safeguarding and significant events. There were also systems in place to monitor and improve quality (including regular meetings where patient outcomes performance was reviewed and action plans developed as necessary). Systems were in place to identify and managerisk (for example an infection control audit took place in December 2014).

Patient participation group members spoke positively about how the practice listened and acted on patient feedback. There was a strong focus on continuous learning and improvement at all levels of the organisation. Clinicians undertook part time undergraduate and post graduate teaching roles; and staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice.

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. Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance (including the Mental Capacity Act 2005). Nationally reported data showed that the practice performed better than the Haringey and England averages for assessment of conditions commonly found in older people such as dementia. Seasonal flu vaccination rates for patients aged 65 and older was also above average.

We noted that the practice was responsive to the needs of older people offering, for example home visits, rapid access appointments and extended appointment slots. Older patients spoke positively about how they were treated by staff and we noted that they were well represented on the Patient Participation Group. Patients aged over 75 had their own named GP and were offered annual health checks.

Records showed that the practice routinely reviewed the care of patients on its palliative (end of life) care register and that it worked with palliative care nurses in the care and treatment of patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. We noted that 31% of patients had a long standing health condition and the practice outlined how it worked to improve outcomes. For example, we were told that longer appointments and home visits were available when needed. Patients had a named GP and practice nurses regularly reviewed patients on long term condition registers to check that their health and medication needs were being met. Patients with long term conditions told us that clinicians provided sufficient information to enable them to make informed decisions about their care and treatment.

We noted that QOF performance data was routinely used at weekly clinical meetings to monitor and review patient outcomes. We also saw evidence of how practice staff worked with other health care professionals (such as district nurses) to deliver a multidisciplinary and coordinated package of care. Clinical audits were routinely used to improve outcomes for people with long term conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates at twelve months, twenty four

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months and five years were better than the average for Haringey practices. Appointments were available outside of school hours and the premises were suitable for children and babies (for example baby changing facilities were available). Practice staff were aware of local safeguarding contacts and knew how to escalate concerns. The practice ran a drop in sexual health clinic which was particularly responsive to the needs of young patients. One of the partner GPs specialised in ante natal care and women's health. The practice safeguarding GP lead met with a local health visitor every six weeks to review "at risk" children. Arrangements were also in place so that GPs could request a health visitor home visit if they had a concern. GPs had experience of contributing to child protection hearings in person or by submitting reports. All child accident and emergency admissions were logged and those with high attendance were reviewed. The practice had processes in place to prioritise seeing acutely ill children and young people. Chlamydia testing was available for young people and other population groups. The practice safeguarding lead was also child protection lead GP for Haringey CCG.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified; and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included, telephone consultations, early morning appointments and also online appointment booking and repeat prescriptions facilities. A Saturday clinic had also recently been introduced. However, some patients fedback that it was difficult to get through to the practice by phone. The practice offered a full range of health promotion and screening information that reflected the needs of this age group. The practice's website contained links to NHS Choices healthy living advice webpages.

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 held a register of patients living in vulnerable circumstances. Patients with learning disabilities were offered annual health checks and longer appointments. We also noted that "easy read" pictorial leaflets were available, outlining various treatments and conditions.

Staff knew how to recognise signs of abuse in vulnerable adults. They were also aware of their responsibilities regarding information

Summary of findings

sharing, documenting safeguarding concerns and contacting relevant agencies in normal working hours and out of hours. The practice offered interpreting services in a range of languages including British Sign Language (BSL).

We noted that 11% of patients had a caring responsibility (above the England average) and were told that the practice routinely referred patients requiring support to a local carer support network. We also noted that carers information was provided in the practice reception and on the practice website.

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 experiencing poor mental health and GPs stressed the importance of reviewing patients' physical as well as mental health. We noted for example that the practice performed slightly better than the local average for patients with poor mental health who had a record of a blood pressure check on file in the preceding twelve months.

The practice offered flexible appointments such as evening appointments (when the practice was less busy) as we were told that this was preferred by many patients experiencing poor mental health. The practice also had systems in place to support patients presenting with acutely poor mental health and routinely referred patients with less severe symptoms to specialist local voluntary sector organisations. We noted that the practice's QOF performance was better than the Haringey and England practice averages for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis. The practice also hosted monthly consultant psychiatrist; and regular clinical psychologist and mental health counselling sessions.

Summary of findings

What people who use the service say

During our inspection, we spoke with eight members of the practice's Patient Participation Group (PPG). They spoke positively about patient care and about how the practice listened and acted on the group's concerns.

We also reviewed 38 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 almost uniformly positive with key themes being that staff were respectful, that they listened and that they were compassionate. We noted that the patient profile ranged from newly registered patients to those who had been with the practice for more than ten years.

During our inspection, we also used existing patient feedback to guide our discussions with patients. For example, the NHS England GP national patient survey 2014 highlighted that 67% of respondents were satisfied with the surgery's opening hours (compared with the local CCG average of 72%). The practice was able to demonstrate how they had acted on this feedback; highlighting for example the recent introduction of a Saturday clinic. None of the eight PPG members we spoke with or the 38 comment cards we looked at identified surgery opening times as an area of concern.

Overall, the patient survey highlighted that 93% of respondents said they would recommend the surgery to someone new to the area.

The Vale 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 granted the same authority to enter the registered person's premises as the CQC lead inspector.

Background to The Vale Practice

The Vale Practice is located in Haringey, 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 Vale Practice has a patient list of approximately 8,800. Approximately three percent of patients are aged 65 or older and approximately 22% are under 18 years old. Thirty one percent have a long standing health condition and 11% have carer responsibilities.

The practice is open between 08:30am and 7.00pm Monday to Wednesday and 08:30am and 6.30pm Thursday to Friday. Appointments are from 08:30am to 1pm and 2pm - 6pm daily. A Saturday morning clinic is also offered.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions, smoking cessation and musculo skeletal clinics. The staff team comprises five GP partners (three female, two male), nurse practitioner, practice manager and a range of administrative staff.

The health of people in Haringey is varied compared with the England average. Deprivation is higher than average and about 31.2% (16,400) children live in poverty. Life expectancy for women is higher than the England average. However, there are also areas of relative affluence.

Life expectancy is 7.7 years lower for men and 3.4 years lower for women in the most deprived areas of Haringey than in the least deprived areas.

By aged 10, 23.4% (569) of children are classified as obese (worse than the average for England). Levels of teenage pregnancy are worse than the England average. Levels of GCSE attainment,

breastfeeding and smoking at time of delivery are better than the England average.

In 2012, 18.8% of adults were classified as obese, better than the average for England. Estimated levels of adult physical activity are better than the England average. Rates of sexually transmitted infections and TB are worse than average.

In Haringey, strategic improvements in health and wellbeing are led by the borough's Health & Wellbeing Board; comprised of Haringey Council, Haringey CCG, Haringey Healthwatch and other health stakeholders. Priorities in Haringey include reducing childhood obesity and teenage pregnancy, reducing the life expectancy gap especially in men and improving mental health.

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.

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 January 2015. During our visit we spoke with a range of staff (GPs, nurse practitioner, practice nurse, practice manager, office manager and reception staff) and spoke with patients who used the service including PPG members. We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients shared their views and experiences of the service.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety including reported incidents and comments/complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, the practice had developed a poster guiding staff on possible signs of child abuse. Clinical and non-clinical staff had a good understanding of the system and of how concerns could be escalated. The practice also had a safety alert protocol detailing the procedure for sharing received drugs alerts throughout the practice. Staff knew their roles and accountability in this process. There were effective arrangements in place to report safety incidents in line with national and statutory guidance.

We were also told that the practice had a good working relationship with the local pharmacy which was an additional safety check regarding drugs recalls, supply issues and practice prescribing patterns.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at five events recorded since February 2014. They included a record of the area of concern, staff learning and evidence of subsequent changes to how the service was delivered. For example, an incident with a baby experiencing breathing problems had resulted in a number of changes including central relocation of emergency drugs, introduction of new systems for checking emergency oxygen and also staff guidance on how the practice's clinical system could be used to summon assistance. Records also showed that the incident was discussed at a subsequent team meeting.

Records showed that significant events were a standing agenda item at monthly clinical education meetings. A GP partner had lead responsibility for significant events including sharing learning amongst staff and helping them to understand and fulfil their responsibilities to raise concerns and report incidents or near misses.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. GPs and nurse practitioner were Level 3 trained in child protection and had also received vulnerable adults safeguarding training. Non-clinical staff had attended basic children and vulnerable adults safeguarding training within the last three years. When we spoke with non clinical staff they could describe possible types of abuse (including in older patients) and knew how and to whom they would report or escalate a concern.

One of the partner GPs was designated safeguarding lead for the practice and also child protection named GP for the local CCG. We asked how their CCG role helped the practice safeguard patients from the risk of abuse. They told us that the practice's child protection training incorporated learning from past child protection cases in the borough (anonymised) and also stressed the importance of multi-disciplinary team working with health visitors and midwifes.

The practice safeguarding lead met with a local health visitor every six weeks to review children on the practice "at risk" register or otherwise deemed vulnerable. The meetings were diarised in the practice electronic diary and GPs could request that specific children be added to the meeting discussion. The safeguarding lead fed back the outcomes of this meeting to the relevant GPs and patient notes were updated. Arrangements were also in place so that GPs could request a health visitor home visit if they had a concern. We also noted that GPs had experience of contributing to serious case reviews and child protection hearings.

The practice had a chaperone policy. We were told that non clinical staff did not undertake chaperoning duties unless they had undertaken formal training.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients experiencing poor mental health.

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 clear policy for ensuring that medicines were kept at the required temperatures. This also included action to take in the event of a power failure. We noted that medicines

refrigerator temperatures were recorded on a daily basis and were within the required parameters. The practice did not hold Controlled Drugs on the premises. Medicines were within their expiry date.

We saw evidence that the practice undertook medicines audits triggered by NICE guidance. For example, an audit had taken place in 2013 to ensure that the effectiveness of prescribed anticoagulant medicine (used to stop blood from clotting) was being monitored. The first round of the audit highlighted that only three of fifteen patients were being monitored. Following contact with patients and a review of practice systems, the 2014 follow up audit highlighted that all sixteen patients had had a measurement within the last twelve weeks.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All clinical, communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment. Consultation rooms had vinyl flooring and we noted that clinical waste was stored securely away from patient areas whilst awaiting collection. 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 manager and nurse practitioner shared Infection Prevention and Control (IPC) lead duties and were jointly responsible for ensuring effective infection control throughout the practice. We noted that the nurse practitioner was slightly overdue their annual infection control refresher training by two months. Personal protective equipment such as gloves and aprons were readily available for staff to use.

The practice had an infection control policy and we noted that in accordance with the policy, infection control audits took place every six months. We looked at the action plan arising from the latest audit (December 2014) and were able to confirm for example, that a legionella risk assessment (legionella is a germ found in the environment which can contaminate water systems in buildings) had since taken place and that that no issues had been identified.

Equipment

We saw evidence of calibration of relevant equipment within the last twelve months including electronic blood pressure machines, weighing scales and defibrillator. Fire alarm and portable appliance testing (PAT testing) had also taken place within the last twelve months.

Staffing & Recruitment

The practice had systems in place to ensure that staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements.

The practice had recruitment procedures in place that ensured staff were recruited appropriately. Most non-clinical staff had staff had been employed by the practice for more than five years and we noted that some DBS checks had been undertaken. Where this was not the case, we were told that a risk assessment had been undertaken outlining how the practice had reached this decision. However, this was not available for review. We noted that new staff completed an induction which included infection control & prevention, health and safety and an overview of staff members' roles. DBS checks were on file for all clinical staff. Staff told us there were usually enough staff to maintain the smooth running of the practice and we saw evidence that systems were in place to keep patients safe.

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 annual, bi-annual and monthly checks of the building and equipment, infection control, medicines management, staffing and dealing with emergencies. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Records showed that identified risks were routinely discussed at clinical meetings and partner meetings.

Arrangements to deal with emergencies and major incidents

There were sufficient systems in place to deal with a medical emergency. The practice had an automated external defibrillator (used to attempt to restart a person's heart in an emergency), emergency medicines and emergency oxygen. These were within expiration and we noted that an allocated nursing staff member undertook

Good

Are services safe?

regular checks. Clinical staff had received cardiopulmonary resuscitation (CPR) training within the last twelve months. Non clinical staff had received CPR training within the last three years.

Plans were in place to respond to emergencies and major situations. The practice had a business continuity plan which described to staff what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure, and contained relevant contact details for staff to refer to (such as support numbers in the event of an electrical power failure). If the practice had to close urgently, there was a reciprocal arrangement in place with a nearby practice which used the same clinical system, therefore minimising disruption. The plan had been reviewed in the last twelve months and we noted that staff understood their roles and responsibilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure that patients' care and treatment was assessed, planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This included use of Quality and Outcomes Framework (QOF- a national performance measurement tool). For example, QOF data showed that at 84% the practice performed better than the Haringey (81%) and England (76%) averages for patients with hypertension (high blood pressure) aged 16-74 who had had an assessment of physical activity within the preceding twelve months. This assessment is identified as best practice by the National Institute for Health and Care Excellence (NICE). We also noted that at 59% the practice performed better than the Haringey practice average (52%) for newly diagnosed patients with depression who had had a follow up review within the target 35 days.

GPs undertook part time GP appraiser, undergraduate teaching, lead CCG and post graduate teaching roles; and staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice. Records showed that the practice routinely discussed changes to guidance and best practice including NICE guidelines.

GPs led in specialist clinical areas such as musculo skeletal care, diabetic care, heart disease and asthma and the nurse practitioner supported this work, which allowed the practice to focus on specific conditions. GPs told us that their part time undergraduate and post graduate medical teaching roles enabled them to support staff in continually reviewing, discussing and sharing clinical best practice.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients including data input, scheduling clinical reviews, managing child protection alerts and medicines management. Information was collated by the practice manager and used to support the practice's clinical audits.

Information about patient's care and treatment, and their outcomes, was routinely monitored and information used to improve care. For example, weekly clinical meetings included a review of children in need.

During 2014, the practice undertook four clinical audits (two of which had been completed). The practice was able to demonstrate how they had been used to improve patient outcomes. For example, in January 2014, the practice undertook an audit of diabetic patients to assess whether there was a difference between expected and recorded incidence of diabetes. This included 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 only 50% of patients with gestational diabetes had been screened for type 1 or type 2 diabetes within the past 12 months. Consequently, the audit recommended that all patients who had not been screened within the last year be invited for screening. When screening rates were re-audited in December 2014, they had increased to 72%.

The practice performed better than the England and/or Haringey practice average in a number of Quality and Outcomes Framework (QOF) clinical targets for the year ending April 2014. For example, the childhood immunisation rates for eligible infants up to twelve months for "5-in-1" vaccine to boost protection against five childhood diseases including tetanus and whooping cough was 94% (compared with the Haringey practice average of 92%). We also noted that at 86%, practice performance on children up to age five having received a 5-in-1 booster, was slightly better than the Haringey practice average (85.7%).

Practice QOF performance on diabetic care was slightly below the Haringey practice average regarding percentage of diabetic patients who had had a dietary review in the last twelve months (79% compared to 82%). However, performance on newly diagnosed diabetic patients who had been referred to an education programme within nine months of diagnosis was slightly better than the Haringey practice average (89% compared to 87%).

Practice performance was also better than Haringey and England practice averages for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis (59% compared to 52%).

We also noted that at 75%, the practice performed better than the Haringey and England practice averages for uptake of seasonal flu vaccine for patients aged 65 and older (respectively 73% and 71%).

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date regarding mandatory training (for example safeguarding (children and vulnerable adults) and basic life support). We noted a good skill mix amongst the GPs and also noted a mixture of female and male GPs. We noted that GPs were up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation within the last 12 months. 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.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had completed annual appraisals within the last 12 months where performance was reviewed and training needs identified. They told us that although formal supervision meetings did not take place, they felt supported in their roles.

We noted that the practice had recently joined a local GP federation with ten other local practices to provide a Saturday morning clinic. GPs spoke positively about how the service had enabled the practices to pool clinical best practice and expertise.

Working with colleagues and other services

The practice had systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. For example, regular multi-disciplinary meetings took place with district nurses and health visitors; and we were told that it was routine for GPs and end of life nurses to synchronise home visits so that care was coordinated. Clinicians were regularly invited to present at clinical meetings to develop joint working opportunities and we also noted that systems were in place to signpost or refer patients to specialist voluntary sector agencies including domestic violence and carer support services.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. When we reviewed the system we saw that patients were referred in a timely manner and that all the information needed for their ongoing care was shared appropriately. We also noted that incoming correspondence was processed in a timely fashion.

However, although practice meeting action logs showed that it continually sought to improve information sharing (for example regarding choose and book hospital communications), there was no formal audit system in place to assess the completeness of records and identify action to be taken where necessary.

Consent to care and treatment

Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005 and records showed that some GPs had received training in this area and also in Deprivation of Liberty Safeguards. Systems were in place for situations where patients lacked the mental capacity; ensuring that 'best interests' decisions were made and recorded in accordance with legislation. We noted that the practice did not undertake home visits at nursing or residential homes. GPs also demonstrated a clear understanding of Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

Three of the partner GPs sat on various governing bodies of Haringey CCG and we were told that the practice worked closely with the CCG to share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area and is used to help focus health promotion activity.

It was practice policy to offer a health check with the nurse practitioner registering with the practice. We noted that a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation. The practice also offered a full range of immunisations for children, travel vaccines and flu

Good

Are services effective?

(for example, treatment is effective)

vaccinations in line with current national guidance. Latest available performance data for immunisations at twelve months, twenty four months and five years was above the average for Haringey practices. We also noted that seasonal flu vaccination rates for patients over 65 was slightly better than the Haringey practice average; as were dementia diagnoses rates.

Performance on newly diagnosed diabetic patients who had been referred to an education programme within nine months of diagnosis was slightly better than the Haringey practice average (89% compared to 87%).

We noted that at 78%, practice performance on the percentage of diabetic patients who had had a dietary review in the last twelve months was below the Haringey practice average (82%). Practice data on women who had had cervical screening within the last five years (76%) was slightly above the average for Haringey practices (75.8%) but slightly below the England practice average (76.9%).

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

Before our inspection, we noted NHS England 2014 national GP patient survey feedback that 91% of respondents found receptionists helpful. When we spoke with patients they 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. The practice offered a chaperone service which was publicised in reception.

During the inspection, we observed that the reception desk and waiting area were in very close proximity and that conversations between the receptionist and patients could easily be overheard.

None of the patients we spoke with expressed concern about privacy and told us that reception staff respected their privacy and confidentiality. When we asked a member of the reception team how they maintained patient privacy, examples included referring to a patient's NHS number and not their name during phone conversations in reception and using an adjacent meeting room if a patient wanted to discuss something in private. Privacy was not highlighted as a concern in any of the 38 comment cards we reviewed.

Care planning and involvement in decisions about care and treatment

The NHS England 2014 national GP patient survey noted that 88% of respondents felt that the last GP they saw or spoke to was good at involving them in decisions about their care. Eighty percent fed back that the last GP they saw or spoke to was good at explaining tests and treatments. We also noted that 91% of respondents said that the last nurse they saw or spoke to was good at listening to them and that 100% had confidence in the last nurse they saw at the practice.

This was consistent with patient feedback on the day of the inspection. Common themes were that staff explained clearly, showed empathy and that patients had sufficient information to be able to make informed decisions about their care.

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). 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

Notices in the patient waiting room, on the TV screen and patient website advised people how to access local and national support groups and organisations. 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, 89% of respondents fed back that the last GP they saw or spoke to was good at treating them with care and concern. This was consistent with face to face and comment card feedback which highlighted that staff responded compassionately and provided support when required such as during times of bereavement or prolonged treatment.

The practice signposted patients to organisations providing specialist support such as domestic violence and carers support. End of life care nurses regularly attended multi-disciplinary meetings at the practice and we were told that GPs and end of life care nurses synchronised the timing of home visits care to ensure that emotional support and caring support were coordinated. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked.

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 provided in the practice reception, on the practice website and in patient participation group leaflets.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a range of appointment options to meet the needs of its patient groups including appointment booking by phone, online or in person. Early morning appointments were available Monday – Friday (8.30am) and late evening appointments Mondays – Wednesday (7.30pm). A Saturday morning clinic had also recently been introduced. The practice provided a named GP and extended appointment slots for patients aged over 75 years or who had a learning disability. Home visits were also available as well as telephone consultations. Records showed that the practice had reached the target 2% requirement for care plans for over 75 year olds. There had been very little turnover of staff during the last five years which enabled good continuity of care.

The practice also offered a range of clinics to meet the needs of its patient groups including ante natal clinics, sexual health clinics and psychotherapy. Targeted activity took place such as a seasonal "drop in" flu clinic for patients aged sixty five and over; and we noted that QOF performance on this indicator was better than Haringey and England practice averages.

The practice was aware of its population group profile and used QOF and staffing to respond to patient need and improve outcomes. For example 22% of patients were under 18 and we noted that the clinical staff included expertise in antenatal care and children with asthma. Child immunisation rates were better than the average for Haringey and England practice averages.

We noted that 31% of patients had a long standing health condition and the practice was able to demonstrate how clinical audits were used to respond to patient need and improve outcomes (for example through a diabetic screening audit).

Information about the needs of patients using the service was used to inform how services were planned and delivered. The practice had an active Patient Participation Group (PPG - a patient led forum for sharing patients' views with the practice). The chair of the PPG spoke positively about how the groups' views were taken on board (for example the introduction of a Saturday clinic to improve patient access). Other examples of how the practice acted on patients' needs included the employment of additional staff to cope with demands on the practice telephone system and redecoration/expansion of the reception area. We noted that the group had an action plan which identified the above and other areas for improvement although we noted that it did not include time scales.

Tackling inequity and promoting equality

We noted that the practice entrance was wheelchair accessible, although the reception/patient waiting area were not large enough to easily accommodate patients with wheelchairs or pushchairs. Clinical rooms allowed easier access. There was a hearing loop at reception for patients with a hearing impairment and the practice made use of an interpreter service (including British Sign Language interpreters) to ensure patients whose first language was not English could access the service. Toilets were wheelchair accessible and contained baby changing facilities.

The reception desk included a lowered section to enable ease of access for wheelchair users and children. We noted that the practice web site was available in local community languages such as Polish and Turkish. There were also translated materials in reception although this did not include the practice complaints policy or new patient information leaflet. We were told that the practice staffing team was multi-cultural and spoke a range of local community languages.

The practice had recognised the needs of different groups in the planning of its services. A receptionist outlined the steps that he and reception colleagues routinely undertook to help patients who needed additional support to understand and be involved in their care. The appointments system alerted staff when vulnerable patients contacted the practice so that extended appointments or BSL interpreter could be booked as necessary. The practice also offered "easy read" pictorial leaflets for patients with learning disabilities. We noted that a range of support was offered to carers including signposting to a local carers support network.

Annual health checks were provided for patients who experienced poor mental health and we saw that at 82%, the practice's QOF performance on cervical screening test of women experiencing poor mental health was significantly above the Haringey average (73%). We noted

Good

Are services responsive to people's needs?

(for example, to feedback?)

that the practice offered flexible services and appointments for people with poor mental health including evening appointments (when the practice was less busy) as this was preferred by many patients.

The practice provided text appointment reminders to all patients which we noted was of particular support to patients with a hearing impairment or who were living with dementia. A screen with the name of the next patient to be seen was located in reception which was responsive to the needs of patients with a hearing impairment.

Access to the service

Appointments were available from 8.30am-1pm and 2pm - 7.30pm on Monday and 8:30am-1pm and 2pm- 6:30pm Tuesday to Friday. The practice offered fifteen minute appointment slots as standard and longer appointments were available for people who needed them such as patients with a learning disability and those with long-term conditions.

Comprehensive appointments information was available on the practice website. This included information on how to arrange urgent appointments, home visits and how to book appointments online. An online repeat prescription facility was also available.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. For example, if patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. This was also detailed on the website. Patients over 75 had a named GP and home visits were made to those patients who needed one.

We noted that the practice had recently entered into a collaborative arrangement with ten other practices to provide a Saturday morning clinic. Patients spoke positively about the new service and about how it was responsive to patient's needs.

Records showed that the practice had recently employed additional administrative staff to process phone calls during busier periods. We noted that 95% of respondents to the NHS England 2014 national GP survey had fed back that it was easy to get through to the surgery by phone (compared to the Haringey practice average of 70%).

Listening and learning from concerns & 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 to the practice.

We saw that information was available in reception and on the practice website to help patients understand the complaints system. This included advice on how patients could escalate complaints to the Health Service Ombudsman. Patients told us they were aware of the process to follow if they wished to make a complaint but had not needed to make a complaint about the practice.

Records showed that the practice reviewed complaints to identify themes or trends which could be used to improve the service. We looked at the latest available report (Jan-Dec 2014) and saw that all nine complaints had a learning outcome.

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 provide high quality patient care to all patients. We spoke with a range of staff including reception staff, nurse practitioner and GPs; all of whom described a patient centred approach to delivering care characterised by 15 minutes appointment slots, a dedication to engaging each patient in decision-making and by listening. We did not see evidence of a business plan but discussions with staff and review of staff and clinical meeting minutes highlighted that the practice's focus was upon good quality patient centred care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We noted that these had been reviewed in the last twelve months. We also noted that partners undertook lead roles (for example on safeguarding and significant events). We did not see a record confirming that practice staff had read the policies but staff generally demonstrated an understanding. For example, staff we spoke with were aware of the practice's safeguarding lead and how to escalate a concern.

The practice undertook regular clinical audits in order to improve patient outcomes and we noted that clinical meetings discussed findings. These meetings also included discussion about performance (such as QOF performance) and risk (such as significant events analyses).

Leadership, openness and transparency

There had been very little turnover of staff during the last five years which enabled good continuity of care. Records showed that monthly team meetings took place and we saw that leadership issues such as premises update were communicated. Staff told us that there was an open culture at the practice and that they felt comfortable raising issues at team meetings.

We saw evidence that senior GPs encouraged supportive relationships among staff so that they felt valued and supported. We also saw that the practice's significant events procedure was used to provide positive feedback to staff.

The service was transparent, collaborative and open about performance. Records showed that QOF performance was regularly reviewed and there was evidence that audits were used to improve patient outcomes (for example regarding diabetic care).

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

We saw evidence that the practice had acted on patient feedback from surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) including representatives from various population groups such as people with long term conditions, older people and Black and minority ethnic communities. The PPG developed an annual action plan with the practice and we saw that some elements (such as redecorating reception) had been implemented. However, we also noted that there were no associated timescales.

The practice generally sought and received staff feedback at monthly team meetings and there was evidence that staff members' views were sought and acted upon. Staff told us they felt supported by partner GPs and informed and involved in decision making.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Clinical staff had completed a range of post graduate study in areas such as sport medicine and long term conditions. Partner GPs held lead positions on the local CCG regarding ante natal care, women's health and patient access.

GP partners told us that they often lunched together and spoke positively about their willingness to learn from each other. Significant events and complaints were discussed at monthly, non clinical staff team meetings to share learning and improve patient outcomes.

There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice was a teaching practice and we noted that GPs undertook part time undergraduate and post graduate teaching. One of the GPs was also a GP appraiser whilst another led on a CCG risk stratification pilot project to minimise unplanned hospital admissions. They spoke positively about how this helped ensure that care was based upon latest guidance and best practice.