

# The Ross 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

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Ross Practice on 15 December 2015. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment, however not all staff had received dedicated infection control and prevention training.
- 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 there was a delay if they wanted to make an appointment with a named GP. Urgent appointments were 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.
- The practice obtained and acted upon feedback from the 'Friends of the Ross Practice' group. The 'friends' group supported the practice by raising money to buy equipment for the practice to use to benefit the patients. The practice was in the process of forming a PPG.
- There was limited awareness of Duty of Candour, however the provider had plans to improve this awareness and staff we spoke with told us that they would highlight any concerns they had regarding service provision.

# Summary of findings

The area where the provider should make improvements is:

- Ensure that any references accepted verbally are documented and the paperwork kept in the relevant staff member's personnel file.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting, recording and investigating significant events which staff were aware of.
- Lessons were shared with relevant staff to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, people received reasonable support, truthful information, a verbal or written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Risks to patients were assessed and well managed. The practice was especially proactive with regards to alerts relating to medicines.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data showed most patient outcomes were at or above average for the locality. For example, the number of patients with chronic obstructive pulmonary disease (COPD) receiving an annual review which included nationally recognised assessments was above the CCG and national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits were often linked with safety alerts and demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and an assessment of training needs for the majority of staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.

### Are services caring?

The practice is rated as good for providing caring services.

Good



- Data showed that patients rated the practice in line with others for their overall experience of the practice.

# Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Staff were able to give us examples to demonstrate how patient's choices and preferences were valued and acted on.
- 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.
- The practice contacted newly bereaved families. In some cases where the patient had been cared for by unpaid carers, such as family or friends, for an extended period the practice sent a card which included a message saying what a good job the carer had done in supporting the patient.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met peoples' needs.
- There were innovative approaches to providing person-centred care.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- 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 relevant staff, and where applicable the complainant was made aware of actions that would be done to prevent future incidents.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.

Good



## Are services well-led?

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

Good



# Summary of findings

- Although the practice had no formalised vision and strategy all staff we spoke with told us that the practice goal was to deliver high quality care, a caring service and promote good outcomes for patients.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider and staff had limited awareness of the Duty of Candour. However the partners encouraged a culture of openness and honesty, and staff told us that they would report any concerns they had about the service provided.
- The practice had systems in place for knowing about notifiable safety incidents
- The practice proactively sought feedback from staff and patients, which it acted on, through staff meetings, the GP survey and the practice's own patient survey.
- There was a long established 'Friends of The Ross Practice' group as well as a patient participation group in the process of being set up. The 'Friends' group provided feedback on any issues raised by patients.
- There was a strong focus on improvement especially related to patient outcomes.

# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as good for the care of older people.

Good



- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were comparable or higher than other practices nationally. For example, the practice offered patients aged 65 and older a flu vaccination, and performed higher than the national average for uptake of this vaccination.
- The practice had plans to engage with other practices in the CCG, with above average outcomes for this patient group, to improve the services that they offered to older people.
- A room was made available to a visiting phlebotomy service, so patients could choose to have blood tests done at the practice instead of at the local hospital.
- The practice offered annual birthday recalls where the patient's records were looked at and any reviews, tests or checks were completed at the same time.
- A room was made available for a monthly drop in hearing aid repair service for all Harlow patients (not just those registered with the service).

### People with long term conditions

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

Good



- Nationally reported data showed that outcomes for patients for long-term conditions were comparable with other practices nationally. For example, numbers of patients with long-term conditions, such as diabetes receiving appropriate reviews were slightly higher than the national average.
- Home visits were available when needed.
- Where the practice was able to provide or source a service for their patients, to avoid them having to make a trip to the local hospital, they did this.
- Sign posting information for support groups was evident in the reception area.
- The practice offered annual birthday recalls where the patient's records were looked at and any reviews, tests or checks were completed at the same time.

# Summary of findings

## Families, children and young people

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

- There was a dedicated room with a baby changing station; this room also had chairs so if a mother wished to breastfeed in private she could do so. There was sufficient space for siblings to be in the room too.
- There was a child friendly area at the back of the waiting room. Some of the consulting rooms had elements in them that would put young children at ease, such as cuddly toys and cartoon characters.
- The practice area had a higher level of income deprivation affecting children than the England average. 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 high for all standard childhood immunisations.
- Nationally reported data showed that outcomes for patients for uptake of cervical smears were comparable with other practices nationally.
- We saw evidence of joint working with midwives and health visitors in the form of regular meetings to discuss patients.

Good



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

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

- The practice made available urgent appointment slots at the end of clinic.
- Patients could have a telephone consultation if a face to face consultation was not required.
- A room was made available to a visiting phlebotomy service, so patients could choose to have blood tests done at the practice instead of at the local hospital.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered a pre-bookable weekend service that was based in the GP practice next door but within the same building.

Good



## People whose circumstances may make them vulnerable

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

Good





# Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers 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.
- There were policies or arrangements to allow people with no fixed address to register or be seen at the practice. The practice encouraged word of mouth referrals. Patients were signposted to a local hostel.
- There was a gypsy community in the practice area from time to time, which the practice told us they had built a rapport with.
- The practice had many hard to reach communities within its practice boundaries and looked at personalised solutions to overcome barriers to treatment. For example, if the being in the surgery building made a patient uncomfortable the practice would look at ways to overcome this. Strategies used in the past by the practice included varying the time of appointment, the method of entering the building and the location.
- One of the GP's role was to spend time with patients with complex needs. We were given an example where the GP spent several visits familiarising the patient to them prior to providing any treatment or examination, in order for the GP to build a relationship with the patient and be able to provide a better outcome for that patient.

## People experiencing poor mental health (including people with dementia)

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

- 82.43% of people diagnosed with Dementia had had their care reviewed in a face to face meeting in the last 12 months.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Good



## Summary of findings

- The practice held a register of patients experiencing poor mental health. The staff were aware of patients within this group and were able to recognise and refer appropriately when increased support was needed.
- The practice felt they could improve the standard of care they offered to people experiencing poor mental health, including seeking guidance on best practice from other practices in the CCG who had very good outcomes for this group of patients.

# Summary of findings

## What people who use the service say

The national GP patient survey results published on 2 July 2015. The results showed the practice was performing in line with local and national averages. 373 survey forms were distributed and 127 were returned. This represented 34% of the practice's patient list.

- 79.4% found it easy to get through to this surgery by phone compared to a CCG average of 63.4% and a national average of 73.3%.
- 84.1% were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 84.8%, and national average of 85.2%.
- 90.9% described the overall experience of their GP surgery as good compared to a CCG average of 81.2% and national average of 84.8%.
- 78.7% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to the CCG average of 71.9%, and national average of 77.5%.
- 90.9% had confidence and trust in the last GP they saw or spoke to compared to a CCG average of 94.7% and a national average of 95.2%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 37 comment cards which were all positive about the standard of care received. The comments cards described the practice as clean, staff as caring, the service as good and attitude of staff especially reception staff as helpful. There were three negative comments, one regarding the length of time to wait for an appointment with a doctor of the patient's choice and two relating to waiting times, although those patients also commented on how good the care and staff were.

We spoke with five patients during the inspection. All five patients said they were happy with the care they received and thought staff were approachable, committed and caring. They also commented that waiting times on the day depended on the doctor they were seeing. The NHS Choices website at the time of our inspection stated all of the patients (six responses) would recommend the practice to friends and family.

## Areas for improvement

### Action the service **SHOULD** take to improve

- Ensure that any references accepted verbally are documented and the paperwork kept in the relevant staff member's personnel file.

## Outstanding practice

One of the GP's role was to spend time with patients with complex needs. We were given an example where the GP

spent several visits familiarising the patient to them prior to providing any treatment or examination, in order for the GP to build a relationship with the patient and be able to provide a better outcome for that patient.

# The Ross Practice

## Detailed findings

### Our inspection team

#### **Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

## Background to The Ross Practice

The practice was established in 1955 in the garage of Dr Ross' house. The practice has since moved twice and two of the current partners joined the practice in the mid-1980s. The practice is based in a leased building with another GP practice and various health professionals from South East Partnership Trust (SEPT).

The current patient list size of the practice is 9706. There are six GP partners, two female and four male and two female salaried GPs. There are two female practice nurses and two female health care assistants (HCAs).

From time to time the practice is involved in training medical students and also offers a work experience programme to sixth form students considering applying to medical school. Students are only present with consent of the patient and sixth form students are never present for any examinations. At the time of our inspection there were no students at the practice.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments are from 8.45am to 11.30am and 3.30pm to 5.30pm daily. There is a pre-bookable weekend GP/Nurse/HCA service which is based within the building in the neighbouring practice. The practice is part of PELC, a London based on-call service which uses the services of some local GP's. Patients with an urgent problem outside

normal practice hours are directed to PELC via the practice number. Patients are asked to attend the emergency centre or, if necessary, a home visit would be arranged. The PELC service begins at 6.30pm each evening.

Approximately 95% of the practice population are white British, with the remainder of patients mainly Polish, Italian and Chinese. The practice area has high levels of unemployment, housing issues and patients experiencing poor mental health. There is a mixed level of income related deprivation within the area, with children more likely to be affected by income deprivation.

## Why we carried out this inspection

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

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

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 December 2015. During our visit we:

# Detailed findings

- Spoke with a range of staff including GPs, nurses, administration and reception staff.
- Talked with patients and family members who used the service and a member of the 'Friends of Ross Practice' group.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed personnel files and other documentation relating to the running of the practice.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

# Are services safe?

## Our findings

### Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager or a nominated partner of any incidents and there was a recording system available.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared with relevant staff via the computer notifications systems and in meetings, to make sure action was taken to improve safety in the practice. For example, there was an incident involving a medication error. A prescription was issued following a request from another health professional with the incorrect dose prescribed. The prescription was fulfilled by the pharmacist but the dose was queried and was found to be incorrect. The outcome was that the GPs would ensure patients and carers were aware of medication dosages and the conversation taking place would act as a dosage check.

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

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding adults and children. The GPs provided reports where necessary for safeguarding meetings where they were unable to attend. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). There were some staff that had been trained but were not acting as chaperones at the time of our inspection as they were awaiting a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff we spoke with had awareness of infection control and prevention although there was not a formal training programme in place for all staff. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had high levels of antibiotic and non-steroidal anti-inflammatory drugs (NSAIDs are used for pain relief and to reduce inflammation) prescribing which it was aware of and was working with the CCG pharmacy team to bring down. The practice carried out regular medicines audits, often following receipt of national patient safety alerts involving medications, to ensure prescribing was in line with best practice guidelines for safe prescribing. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, documented references were not always seen. The practice manager told us that references were taken over the phone but the conversation was not always documented.

### Monitoring risks to patients

## Are services safe?

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were organised and carried out by the premises landlord. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control. The premises landlord arranged testing and treatment for legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staffing levels were reviewed by the practice manager and adjustments to the rota made as required. The practice did not use locum staff.

### **Arrangements to deal with emergencies and major incidents**

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was a system in place on all the computers in which alerted all staff to any emergency, this was in addition to buttons under consulting room desks which connected directly to the local police.
- All staff received basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. The plan did not specify an actual location if a building relocation was required, however the plan stated that the premises was leased by an organisation with several other buildings that could be used.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines via computer notifications and meetings and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. We saw evidence that where follow up with patients was required this took place and that patient's treatment was changed if appropriate in response to this.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.1% of the total number of points available, with 10.7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This level of exception reporting is slightly higher than usual so we asked the practice to explain the reasons for this. The practice told us that they were aware of this issue and had worked to ensure that exception reporting was reduced for the current year. They told us the exception reporting was due to the level of deprivation in the area and difficulty engaging some groups of patients.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2014 to end of April 2015 showed;

- Performance for assessing and treating patients with diabetes was similar to the national average, with some areas slightly above national average. For example, the

percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 90.65% with the national average of 88.3%. These checks help to identify conditions associated with diabetes such as poor blood circulation and risks associated with this.

- The percentage of patients with hypertension having regular blood pressure tests was above the national average. 89.52% for the practice compared with a national average of 83.65%.
- Performance for assessing and treating patients with mental health conditions was better compared to the national average for most indicators. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record in the preceding 12 months was 94.81% compared with an 88.47% national average.

Clinical audits demonstrated quality improvement.

- There had been several clinical audits completed in the last two years of which we reviewed four. Three of these were completed audits where the improvements made were implemented and monitored. One was not yet due the second cycle.
- Findings were used by the practice to improve services. For example, recent action taken as a result included reviewing the notes of all patients on a specific medication (following a manufacturer alert) and taking appropriate action to ensure that the safety of the patients' on the medication was not compromised.
- The practice participated in local audits, national benchmarking, peer review and two of the partners were active members of the CCG.

Information about patients' outcomes was used to make improvements. For example, nationally available data showed that patients' were unhappy with access to the service therefore the practice introduced online booking service to lessen demand on the telephones in the morning.

### Effective staffing

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

- The practice was in the process of changing the induction programme that all newly appointed staff received to be more structured. Previously although



# Are services effective?

## (for example, treatment is effective)

staff received an induction which covered essential areas of training, such as health and safety and confidentiality, the induction structure varied from person to person.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example discussion at practice meetings. The practice nurse in charge of infection control told us that they used online resources to maintain their knowledge and for latest updates.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff, except the practice manager had had an appraisal within the last 12 months. We spoke with the practice manager regarding this and the support given to them. Despite no formal appraisals or documented one to one meetings, the practice manager informed us that they felt supported and were able to access required training to assist them in their role.
- Staff received training that included: safeguarding, basic life support and information governance awareness.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring people to secondary care and specialist services.

Staff worked together and with other health and social care services to understand and meet the range and complexity

of patients' needs and to assess and plan ongoing care and treatment. Some of those health professionals were based within the same building. Joint working included when patients moved between services, when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated. We also saw evidence of this through the audits completed as a result of patient safety alerts.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood and received training on the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance adding the appropriate clinical read code to the patient's notes as necessary.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- Smoking cessation advice was available on the premises.
- A dietician clinic was held every three weeks to support the practice's diabetic clinic. Group sessions for patients newly diagnosed with diabetes were also held.
- Doctors were able to refer to a weekly physiotherapy clinic held at the practice.

# Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 85.26%, which was comparable to the national average of 81.83%. There was a policy to offer reminders for patients who did not attend for their cervical screening test.

The practice completed a monthly search of all pregnant women and invited in those eligible to receive the whooping cough vaccination.

Childhood immunisation rates for the vaccinations given and flu vaccination rates for patients over 65 years were comparable to CCG and national averages in 2014/15. For example,

- The percentage of childhood 'five in one' Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza immunisation vaccinations given to under one year olds was 94.7% compared to the CCG percentage of 95.5%.

- The percentage of childhood Mumps Measles and Rubella vaccination (MMR) given to under two year olds was 98.4% compared to the CCG percentage of 94.4%.
- The percentage of childhood Meningitis C vaccinations given to under five year olds was 98% compared to the CCG percentage of 95.8%.
- Flu vaccination rates for the over 65s were 75.1%, and at risk groups 41.42%. These were also comparable to national averages (73.24% and 47.04% respectively).

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

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff told us that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- There was a room available for mothers to breastfeed their child in privacy if they preferred.

All of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the 'Friends of the Ross Practice' group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. One comment card spoke positively about the care that they had received preceding and following the death of a loved one.

Results from the national GP patient survey published in July 2015 showed most patients felt they were treated with compassion, dignity and respect. The practice was in line with CCG and national averages for its satisfaction scores on consultations with GPs and nurses, with some areas slightly above the average and some below. For example:

- 85.2% said the GP was good at listening to them compared to the CCG average of 87.9% and national average of 88.6%.
- 83.8% said the GP gave them enough time compared to the CCG average 83.1% and national average of 86.6%.
- 80.3% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average 81.8 and national average of 85.1%.

- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88.4% and national average of 90.4%.
- 89.6% said they found the receptionists at the practice helpful compared to the CCG average of 85.2% and national average of 86.8%
- 90.9% had confidence and trust in the last GP they saw or spoke to compared to a CCG average of 94.7% and a national average of 95.2%.

Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Staff were able to give us examples to demonstrate how patient's choices and preferences were valued and acted on. For example, the practice had many hard-to-reach communities within its practice boundaries and the practice looked at personalised solutions to overcome barriers to treatment. For example, if the being in the surgery building made a patient uncomfortable the practice would look at ways to overcome this. Strategies used in the past by the practice included varying the time of appointment, the method of entering the building and the location.

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

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

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

- 81.6% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and national average of 86%.
- 83.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77.4% and national average of 81.4%.
- 89.7% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88.4% and national average of 89.6%.

## Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language.

### **Patient and carer support to cope emotionally with care and treatment**

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

The practice's computer system alerted GPs if a patient was also a carer. The practice identified carers through the new patient registration forms and through notices in the waiting area. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, a GP contacted them. In some cases where the patient had been cared for by informal carers, such as family or friends, for an extended period the practice sent a card which included a message saying what a good job the carer had done in supporting the patient.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, there was a newly formed 'Neighbourhood' scheme to encourage collaborative working between GP practices within Harlow. The practice was looking to use this initiative to improve the standard of care for certain groups such as the elderly by exchanging ideas and working practices with those practices that were particularly good at managing the care and treatment of that particular group.

- The practice offering longer appointments for people with a learning disability. Appointments for annual health checks for patients with a learning disability were scheduled for the start of the appointment session so the patient would not be kept waiting.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Where the practice was able to provide or source a service for their patients, to avoid them having to make a trip to the local hospital, it did this. For example, if a patient required regular steroid injections.
- In exceptional cases, where the medical condition warranted it, patients could be seen out of normal practice hours if that was only time that a relative could attend with the patient.
- There were accessible facilities, a visual electronic patient call system and translation services available.
- The practice told us that those patients who were either undergoing or had undergone treatment for gender reassignment would be addressed by the name and gender that the person identified with at the time of visiting the practice.
- The practice completed annual reviews around the date of patients' birthdays. All the patient's records were viewed and any tests, checks or reviews required would be arranged to be carried by the relevant members of the practice team on the same attendance.

The practice had some difficult-to-engage patients and had considered how best to ensure they received adequate and appropriate treatment.

- One of the GPs had the capacity within their role to spend time with patients with complex needs. We were given an example where the GP spent several visits familiarising the patient to them prior to providing any treatment or examination, in order for the GP to build a relationship with the patient and be able to provide a better outcome for that patient.
- The practice encouraged word of mouth referrals amongst patients with no fixed abode. When patients were seen they were signposted to a local hostel.
- There was a gypsy community in the practice area from time to time, which the practice told us they had built a rapport with over a period of time.
- The practice held a large register of patients experiencing poor mental health. The staff were aware of patients within this group and were able to recognise and refer appropriately when increased support was needed. The practice gave us examples of how patients from this and other hard-to-reach population groups were sometimes seen by staff when they were out in the local community and if they had any concerns they would encourage the patient to attend the following day.

### Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.45am to 11.30am and 3.30pm to 5.30pm daily. Pre-bookable GP/nurse/health care assistant appointments were available at weekend. In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them. Appointments could be booked via telephone, in person or online. There was a public pay and display car park opposite the building, and the practice was on local bus routes. The practice building was accessible via automatic doors and in the entrance foyer there was an accessible toilet which was provided for all patients.

Results from the national GP patient survey published in July 2015 showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages, with the exception of ability to make an appointment to see or speak with their preferred GP.

- 71.1% of patients were satisfied with the practice's opening hours compared to the CCG average of 69.2% and national average of 73.8%.

# Are services responsive to people's needs?

(for example, to feedback?)

- 79.4% patients said they could get through easily to the surgery by phone compared to a CCG average of 63.4% and national average of 73.3%.
- 36.1% patients said they always or almost always see or speak to the GP they prefer compared to a CCG average of 53.7% and national average of 60%.

People told us on the day of the inspection, and comment cards we received confirmed, that they were usually able to get on the day appointments when they needed them, but there was a delay in gaining access to a preferred GP. We spoke with the GPs regarding this and they discussed with us the difficult balance of individual GPs being able to offer during the day appointments, working in the out of hours services and active engagement in groups like to CCG in order to secure improvements for patients.

## Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system, such as a poster in the waiting area, information within the practice leaflet and on the practice website.

We looked at seven complaints received in the last 12 months and found they were dealt with in a timely way. The responses to complainants showed openness and transparency with dealing with the complaint. Any lessons learnt from concerns and complaints were shared with the appropriate members of staff and action was taken to as a result to improve the quality of care. We saw that where necessary the practice liaised with other organisations, including NHS England, to resolve the complaint satisfactorily. For example, one patient had several allergies noted on their care record however the computer view only showed the first two, this meant that a medicine was prescribed which caused an allergic reaction in the patient. The issue was discussed and measures put in place to avoid a repeat of this occurrence.



# 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

Although there was no formalised vision and strategy for the practice, when we spoke with staff they told us that the practice goal was to deliver high quality care, a caring service and promote good outcomes for patients.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff. Due to a change in computer systems these were in the process of changing to be more accessible.
- A comprehensive understanding of the performance of the practice was maintained and systems put in place to improve areas needing improvement.
- Continuous clinical and internal audit which was used to monitor quality and to make improvements which the practice could evidence had a positive outcome for patients.
- There were good arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider and staff had limited awareness of the Duty of Candour. However the partners encouraged a culture of openness and honesty, and staff told us that they would report any concerns they had about the service provided. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

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

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

- Staff told us the practice held regular team meetings.
- We saw evidence that there was open culture within the practice and staff had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- GPs met daily to provide support to each other and discuss any issues.
- Staff said they felt respected, valued and supported, particularly by the partners and the practice manager in the practice. All staff had opportunities to join the monthly clinical governance meetings.

### Seeking and acting on feedback from patients, the public and staff

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

- The practice had gathered feedback from patients through the 'Friends of the Ross Practice group' and through surveys and complaints received. They were in the process of establishing a patient participation group (PPG) to provide a more critical view of the services they provided. The 'friends' group regularly sat in the waiting area to gather patient views on the service and these were feedback to the practice in quarterly meetings.
- We found that comments made on NHS choices were not responded to by the practice, during our inspection we queried this and were told that if the patients left contact details they would call them, but that they were having ongoing difficulties with responding on the website and were aware that this was something they needed to follow up.
- Staff felt able to provide feedback to the practice manager and partners.

### Continuous improvement

There was a strong focus on continuous learning and improvement, especially with regard to improving patient outcomes. The practice team was forward thinking and part of local schemes such as the 'Neighbourhood'

# Are services well-led?

Good 

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

scheme, a scheme to encourage collaborative working between GPs in Harlow. Two of the partners were also active members of the local Clinical Commissioning Group

(CCG), one was chair and another was the chair of the medicines management part of the CCG. This enabled them to have an accurate view of the practice performance within the area and influence future planning.