

The Gold Street Surgery

Quality Report

**Gold Street, Saffron Walden,
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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 Gold Street Surgery on 16 March 2016. Overall the practice is rated as good.

- Our key findings across all the areas we inspected were as follows:
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised. Outcomes from incidents were shared appropriately.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice took part in peer review and attended post graduate meetings to update their knowledge of best practice.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how

services were provided to ensure that they meet patients' needs. For example, the practice was piloting a multidisciplinary meeting in one of the care homes, in order to improve communication between professionals involved in the resident's care.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, following feedback from the NHS friends and family test the practice recruited two more salaried doctors.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they were managed and responded to, and made improvements as a result. Complainants were informed of the outcome and lessons learned from their complaint.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- Continuous learning was encouraged at all levels both clinical and non-clinical. The practice was keen to maintain, involve and develop staff so there was a high level of satisfaction amongst staff and continuity for patients.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

The areas where the provider should make improvement are:

- Consider taking more proactive steps to improve the identification of patients who are carers.

- Consider how they can improve patient access their preferred doctor.

We saw one area of outstanding practice:

- The practice had undertaken significant work with palliative care patients and patients on their multidisciplinary meeting list to establish decisions on preferred place of care and resuscitation wishes. They had worked with other agencies to ensure that patients end of life choices were fulfilled. The practice had completed an audit and found that 96% of patients had achieved their end of life preferences.

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



- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation. The outcome of investigations was shared appropriately.
- Information about safety was highly valued and was used to promote learning and improvement.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The practice had strong systems in place to monitor and review patients who were taking prescribed medicines which required regular blood tests to ensure their safe use.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.
- Data from the Quality and Outcomes Framework showed patient outcomes were mostly in line with outcomes for the locality and comparable to the national average, with some slightly above and some slightly below. For example, the percentage of patient's with a diagnosis of dementia, who had an annual review in the last 12 months was slightly higher than the national average.
- Clinical audits were relevant to the practice and one audit had arisen from a significant event. Outcomes demonstrated quality improvement.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Administrative staff were proactively trained to complete each other's roles where appropriate.
- There was evidence of appraisals and personal development plans for all staff, with career progression opportunities for all staff where they desired this.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, the community matron visited the practice daily and discussed case management of appropriate patients with the clinical team.

Are services caring?

The practice is rated as good for providing caring services.

- Feedback from patients about their care and treatment was positive.
- We found many examples to demonstrate how patient's choices and preferences were valued and acted on; especially with regards to preferred place of care for patients nearing the end of their lives, and involvement in resuscitation preferences for those with long term conditions or receiving palliative care.
- Data from the National GP Patient Survey showed patients rated the practice higher than or in line with local and national averages for most aspects of care.
- Most patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



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 meet patients' needs. For example, the practice was trialling holding a multi-disciplinary meeting at one of the local care homes with the community matrons.
- The practice had set up a shared clinic with a physiotherapist. This had improved referrals to secondary care and sped up the process of patients being referred for an MRI scan.

Good



Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, following feedback from the NHS friends and family test the practice recruited two more salaried doctors.
- Most patients said they could access same day appointments and services in a way and at a time that suits them. Patients experienced a delay in seeing their preferred GP.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles. The ability to perform each other's roles was encouraged within the administrative teams. Continuous learning and development was a high priority.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. Discussions were held weekly to plan performance areas to focus on and improve.
- The practice carried out proactive succession planning.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Good



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



- The practice told us they had double the national average of patients over the age of 85 and had considered what was required to maximise the service offered to this patient group.
- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice was trialling holding a multi-disciplinary meeting at one of the local care homes with the community matrons.
- Care and treatment of older people reflected current evidence-based practice.
- The practice contacted older people upon discharge from hospital, reviewed their needs and offered appropriate support or referral to support agencies.
- The practice offered a room to a phlebotomy drop in and bookable clinic provided by the local hospital.
- Older people at risk of falls were referred to a dedicated clinic to identify measures to minimise the occurrence.

People with long term conditions

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

Good



- Nursing staff had lead roles in chronic disease management.
- The practice operated a recall system for patients with chronic conditions such as asthma, COPD, cardiac disease, diabetes and chronic kidney disease.
- The practice had a weekly diabetes clinic where patients were seen by either a GP, Dietician or nurse according to their need and outcome of checks completed. Dedicated clinics for other long term conditions were also held.
- Nationally reported data showed that outcomes for patients for most long-term conditions were comparable with other practices nationally. Data for annual reviews of patients with respiratory conditions, such as asthma or COPD were much lower than compared to the national average. The practice were aware and had taken action to improve this. For example,

Summary of findings

they had instigated a weekly nurse led asthma clinic which included telephone reviews for working age patients. We saw evidence that performance in this area had improved as a result.

Families, children and young people

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

- There were strong 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. Where notifications of domestic violence were received the practice ensured staff would be aware of all members of family and extended family who may be affected or at risk following the incident.
- Immunisation rates were similar to the CCG average for standard childhood immunisations. There was a large transient population due to military families living nearby; however the practice had a system in place to follow up those children who did not attend for childhood immunisations.
- The number of patients diagnosed with asthma, on the register, who had an asthma review in the preceding 12 months was much lower than the national average. The outcomes for percentage of patients receiving an annual review were much lower than when compared to the national average however the practice were aware and had taken action to improve this. We saw evidence that performance in this area had improved as a result.
- Clinical staff gave us working examples to demonstrate how children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

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 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.

Good



Summary of findings

- There was a weekly nurse led asthma clinic which included telephone reviews for working age patients.
- 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. Screening included vascular health screening for adults aged 40-74, and lifestyle advice.
- Nationally reported data showed that outcomes for patients for uptake of cervical smears were comparable with other practices nationally. 80% practice average compared with a national average of 81%.
- Nationally reported data showed that outcomes for patients for uptake of bowel and breast screening in the last three years were higher than other practices nationally. For example, 75% of eligible females in the practice aged 50-70 attended for a breast screen compared to a 71% CCG average and a 72% national average.

People whose circumstances may make them vulnerable

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

Good



- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a specially trained GP and nurse lead for patients with a learning disability and longer appointments were available for this group of patients.
- The practice completed annual health checks for those patients with a learning disability, which included, as required, liaison with the community specialist nurse and the psychiatrist. They also had information in an easy read format on self-care and health screening.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. This included supporting vulnerable patients in achieving their end of life preferences.
- The practice had undertaken significant work with palliative care patients and patients on their multidisciplinary meeting list to establish decisions on preferred place of care and resuscitation wishes. They had worked with other agencies to ensure that patients end of life choices were fulfilled. The practice had completed an audit and found that 96% of patients had achieved their end of life preferences.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- There was information available in other languages, such as Polish, which reflected the local population.
- 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.

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).

- The percentage of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, was similar to the national average. 89% practice average compared to a national average of 84%. The practice proactively searched for patients at risk of dementia and invited them in for screening.
- The percentage of patients, on the practice register, with a diagnosis of schizophrenia, bipolar affective disorder or other psychosis, that had an agreed care plan documented in their records, was slightly higher than the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients were sent a letter inviting them into the practice for their annual review. In some cases the practice proactively visited patients at home for reviews.
- The practice carried out advance care planning for patients with dementia and supported end of life decisions.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Good



Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016 showed the practice was mostly performing in line with national averages, with some areas above the local and national average. 276 survey forms were distributed and 138 were returned. This represented 1% of the practice's patient list and was a response rate of 50%.

- 66% found it easy to get through to this surgery by phone compared to a local average of 64% and a national average of 73%.
- 39% of respondents with a preferred GP usually get to see or speak to that GP compared to a local average of 54% and a national average of 59%.
- 90% were able to get an appointment to see or speak to someone the last time they tried compared to a local average of 86% and a national average of 85%.
- 92% described the overall experience of their GP surgery as fairly good or very good compared to a local average of 82% and a national average of 85%.

- 85% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a local average of 74% and a national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards which were all positive about the standard of care received. People told us that they received excellent care, were treated with dignity and respect and felt involved in decisions relating to their care and treatment.

We spoke with four patients during the inspection. All four patients said they were happy with the care they received and thought staff were caring. They told us that when they had needed referrals to other health professional this has been done quickly. The latest friends and family test result available on NHS Choices website showed that 100% of patients would recommend the practice based on five responses.

Areas for improvement

Action the service **SHOULD** take to improve

- Consider taking more proactive steps to improve the identification of patients who are carers.
- Consider how they can improve patient access their preferred doctor.

Outstanding practice

- The practice had undertaken significant work with palliative care patients and patients on their multidisciplinary meeting list to establish decisions on preferred place of care and resuscitation wishes. They had worked with other agencies to ensure that patients end of life choices were fulfilled. The practice had completed an audit and found that 96% of patients had achieved their end of life preferences.

The Gold Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a second inspector, a practice manager specialist adviser and a pharmacist specialist adviser.

Background to The Gold Street Surgery

The practice is based in Saffron Walden, Essex. A large number of the patients on the practice list are older people. The practice has low level of income deprivation affecting both older people and children.

This practice is a teaching and training practice and has medical students and GP registrars in their final stage of training. GP registrars are fully qualified doctors and will have had at least three years of hospital experience. Medical students may observe patient consultations and examinations with the patient's consent.

This practice is also a dispensing practice. This means that patients who do not have a dispensing chemist within a 1.6km radius of their house can get their prescribed medicines dispensed at the practice.

The current list size of the practice is 10075 patients. There are four GP partners, three female and one male, and three female salaried GPs. There are four female practice nurses and two female health care assistants (HCAs).

The practice is open every weekday between 8am and 6.30pm. Morning surgeries are from 8.30am to 12.30pm and afternoon surgeries from 3.30pm to 5pm. Same day appointments run to different time schedules as required.

Pre-bookable extended hours are offered Monday mornings between 7am and 8am. Book on the day evening telephone appointments are available for telephone advice from Monday to Thursday 6.30pm to 7pm. There is a pre-bookable weekend GP/Nurse/Healthcare assistant service, run from Saffron Walden Community Hospital. Appointments for the weekend service can be made through the practice.

The dispensary is open Monday to Friday 9am to 6pm.

When the practice is closed patients are advised to call 111 if they require medical assistance and it cannot wait until the surgery reopens. The 111 provider is currently Integrated Care 24 (IC24) and the out of hours provider is Partnership of East London Cooperative (PELC).

There is a branch surgery at: School Street, Great Chesterford, Saffron Walden, Essex. The School Street branch surgery is open between 8.00am and 12.30pm, plus Monday and Wednesday afternoons between 3.30 and 5.00pm. This is also a dispensing branch.

The branch surgery was not visited as part of our inspection.

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. 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.

Detailed findings

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 16 March 2016.

During our visit we:

- Spoke with a range of staff including GPs, nursing and administration staff.
- Observed reception staff speaking with patients.
- Spoke with patients who used the service and their family members.
- Reviewed an anonymised sample of the treatment records of patients.
- Reviewed comment cards where patients and members of the public 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 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 of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. Staff told us there was an open culture and they felt able to report any concerns they had.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written or verbal apology and were told about any actions to improve processes to prevent the same thing happening again. Learning was also shared with relevant staff within the practice.
- The practice carried out a thorough analysis of the significant events. Learning was disseminated amongst staff through meetings.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice realised, following a significant event, that when a patient passed away that prescribed medicines may present a risk to other persons living in the same home. The practice reviewed its bereavement letters to request that the family bring the medicines into the practice to be destroyed.

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. These arrangements reflected relevant legislation and local requirements. 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 and contact details were readily available to all staff. There was a lead member of staff for safeguarding whom staff were aware

of. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Clinical staff had daily contact with other health professionals so concerns could be discussed and addressed. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained in child protection and safeguarding to an appropriate level.

- Where notifications of domestic violence were received, the practice ensured staff would be aware of all members of family and extended family who may be affected or at risk following the incident.
- A notice in the waiting room advised patients that chaperones were available if required. Notices were also displayed in clinical areas and information was on the practice website. Only clinical staff acted as chaperones. These staff were trained for the role and had received a Disclosure and Barring Service (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. One of the GP partners was the infection control clinical lead, with one of the practice nurses completing the audits. They ensured that the practice was up to date with best practice. There was an infection control protocol in place and staff had received up to date training. The practice manager asked staff to complete a questionnaire on clinical waste management, prior to infection control training and audits, to identify their level of knowledge and ensure training addressed any gaps. 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 medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Every new patient put on a high risk medicine had an alert attached to their computer record. There was a robust system in place for checking at various intervals that necessary reviews had taken

Are services safe?

place. The system included appropriate actions to be taken if those reviews had not taken place. The dispensing team had protocols in place to enable them to change the length of a repeat prescription to ensure that medicines reviews were completed. There were also processes for dealing with uncollected prescriptions.

- The practice carried out regular medicines audits, with the support of the local medicines management teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. All staff were training to NVQ level 2 or 3. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw that the systems in place for providing dispensing to the branch surgery had the same level of safety.
- The dispensary held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place with the CCG for the destruction of controlled drugs.
- We asked the practice how they managed Medicines and Health Regulatory products Agency (MHRA) alerts. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. The practice told us that the information was disseminated and discussed within the practice. The practice ran searches on their patient record system to identify those who may be affected and then completed the necessary actions to ensure patient safety was maintained.

- We found arrangements were in place to minimise errors in updating patient records following discharge from hospital. Each clinician had two monitors on their desk so that when discharge summaries came in they could make updates to the patient record whilst looking at the original summary.
- The practice made effective use of the computerised patient record system. Relevant alerts could be linked to a patient's computer record to ensure the patient was kept safe. This meant that when patients were seen by any of the GPs at the practice, any concerns about the patient were easily identifiable and appropriate and timely action could be undertaken. This included highlighting children at risk in relation to safeguarding concerns.
- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available which identified local health and safety representatives. Each room had a poster with a risk assessment for that room. The practice had up to date fire risk assessments and carried out regular fire drills. We saw evidence that action was taken when issues were identified. 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 and 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 enough staff were on duty. Administrative staff were able to carry out all tasks associated with this role and

Are services safe?

covered for each other. If the practice required a locum they used a locum who had previously worked at the practice and who was familiar with the systems and processes.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the dispensary.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage.

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 from NICE and used this information to deliver care and treatment that met patients' needs. For example, the practice changed their guidance for staff about medicine reviews to comply with NICE guidelines. Following discharge from hospital, the practice now completed a medicines optimisation review with the patient. (Medicines optimisation is an approach that seeks to maximise the beneficial clinical outcomes for patients with an emphasis on safety, governance professional collaboration and patient engagement.)
- The practice showed us other examples of how current evidence based guidance has changed their practice and was able to demonstrate positive impact for patients.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. There was an ongoing audit regarding the medicines optimisation post discharge system.

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 showed the practice had achieved 96% of the total number of points available, with 7% exception reporting compared to a CCG and national exception reporting average of 9%. (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.)

The practice were in line with or better than local and national averages for most clinical performance areas but were an outlier for two QOF (or other national) clinical targets. Data from 2014 to 2015 showed:

- Performance for diabetes related indicators was similar to the 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 92% with the national average of 88%. These checks help to identify conditions associated with diabetes such as poor blood circulation and risks associated with this.
- Performance for mental health related indicators was similar to or slightly better than the national average. For example, the percentage of patient's with a diagnosis of dementia, who had an annual review in the last 12 months was 89% compared to a national average of 84%.
- Performance for two clinical indicators relating to the annual reviews of patients with respiratory conditions was much worse than the national average. For example, the percentage of patient's with asthma receiving an annual review was 11% less than the national average (64% practice, 75% national average). The percentage of patient's with COPD receiving an annual review was 21% less than the national average (69% practice and 90% national average).
- The practice also had higher than average exception reporting for two clinical domains, heart failure (Practice 15%, local average 10% and national average 9%) and rheumatoid arthritis (Practice 18%, local average 11% and national average 7%).

The practice were aware of their clinical performance figures and had appointed a GP partner and member of administration staff to be responsible for reviewing this data weekly. As part of the review they planned which clinical performance area needed improvement and what action was required. For example, as a result of the QOF data the practice had instigated weekly nurse led asthma clinics, including telephone reviews for those who were unable to attend the practice. The practice were able to demonstrate, using the current data for annual reviews of patients with respiratory conditions, that outcomes for these patients had improved. The latest data showed that 77% of patients on the practice register, with a diagnosis of asthma, had received an annual review and for COPD 92%. The practice told us that they were aware that they had a

Are services effective?

(for example, treatment is effective)

low COPD prevalence so they had been trying to proactively identify smokers and ex-smokers and encourage take up of spirometry testing to improve this. The current data was yet to be ratified through audit.

There was evidence of quality improvement including clinical audit.

- The practice undertook one or two audits per year and we viewed four of the audits from the last two years, two of these were two cycle audits where the improvements made were implemented and monitored. One had only just been started and the other audit was a review of expected and unexpected deaths and the care and treatment of those patients. We saw that one audit had arisen following a significant event, regarding dosette box following hospital discharge, at the practice. Re-audit showed that since the incident and changes in processes, that safety in that area had improved.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example, they attended meetings with the local practices and a hospital consultant where case study's from each practice would be discussed to ensure best practice.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Induction programmes were tailored to the individual's role.
- 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. The GP and practice nurse with a lead role in treating those diagnosed with a learning disability had received additional training to undertake this role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.

- 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, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Staff were offered training to assist them with career progression. If additional training was required either for their current role or to learn a new role then this was provided. The practice also welcomed workplace apprentices within the administrative team to work at the practice.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of in-house training and other training. Administration staff also understood and were trained in completing each other's roles.

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 risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets and in-house designed leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice gave midwives access to the computer system so both GPs and midwives could access test results and provide patients with timely care and treatment.
- Test results and incoming letters (such as hospital discharges and Out of Hours reports) were reviewed in a timely way and there were failsafe systems in place for ensuring that any follow up needed was actioned at the appropriate time.

Are services effective?

(for example, treatment is effective)

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated for those patients with complex needs. In addition to this staff spoke daily to community staff, such as community matrons, meaning faster action was able to be taken for this group of patients. The practice proactively identified patients at risk of falls and referred them to a fall prevention clinic for support.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. These were documented in the consultation session notes and reviewed at each attendance. Clinical staff were able to give us working examples of this.
- 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.
- Where a child attended for immunisations with a person other than their parent or legal guardian, written consent or verbal consent in advance was obtained by the practice from the parent or legal guardian.
- Written consent for minor operations was obtained and scanned into the patient's notes.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking or alcohol cessation and advice on weight management. Patients were signposted to relevant services according to their needs.
- Smoking cessation advice was available through the practice and smokers were encouraged to attend.
- The practice operated an annual review for those patients with a previous history of impaired fasting glycaemia, gestational diabetes or for those patients who were classed as clinically obese.
- The practice completed annual health checks for those patients with a learning disability, which included, as required, liaison with the community specialist nurse and the psychiatrist. They also had information in an easy read format on self-care and health screening.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 81%. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were in line with the CCG averages.

- 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 96% compared to the CCG average of 95%.
- The percentage of childhood Mumps, Measles and Rubella vaccination (MMR) given to under two year olds was 96% compared to the CCG average of 94%.
- The percentage of childhood Meningitis C vaccinations given to under five year olds was 98% compared to the CCG average of 95%.

The practice told us that there was a large transient population due to military families living nearby. There were also members of the community for whom English was not their first language. The practice encouraged uptake of the immunisation programme by using information in different languages. They had a system in place to follow up those children who did not attend for childhood immunisations.

Are services effective?

(for example, treatment is effective)

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

The practice ran the Essex Wide scheme 'C-card' in which, following a consultation, patients could obtain free condoms until the age of 25.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous, kind 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.
- When patients wanted to discuss sensitive issues or appeared distressed reception staff could offer them a private room to discuss their needs. There was a notice in reception that advised patients of this facility.

All of the 16 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service, staff were caring and treated them with dignity and respect.

Results from the national GP patient survey, published in January 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was in line with national average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% said the GP was good at listening to them compared to a local average of 87% and the national average of 89%.
- 85% said the GP gave them enough time compared to a local average of 83% and the national average of 87%.
- 96% said they had confidence and trust in the last GP they saw compared to a local average of 95% and the national average of 95%.
- 89% said the last GP they spoke to was good at treating them with care and concern compared to a local average of 83% and the national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to a local average of 89% and the national average of 91%.
- 87% said they found the receptionists at the practice helpful compared to a local average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

The practice told us that they had undertaken significant work, with patients on their multidisciplinary meeting list and with their patients with palliative care needs, to establish both resuscitation wishes and end of life choices. The practice were able to give us working examples of how they had liaised with other agencies to ensure that, even in complex caring situations, patients were supported in their decisions about their preferred place of care. They had carried out an audit to monitor these choices and found that 96% of expected patients had achieved their wishes. The audit also evidenced patient involvement in decisions on their resuscitation status.

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:

- 86% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 86%.
- 88% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and the national average of 82%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 84% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

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

Are services caring?

We saw notices in the reception areas informing patients this service was available. One of the main languages spoken by patients at the practice was Polish and the practice had a GP who spoke Polish.

- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

Notices in reception, the practice leaflet and the practice's registration pack asked patients to identify themselves as carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 62 patients as carers (0.6% of the practice list). When carers were identified they were offered an annual flu vaccination

and the practice proactively requested consent letters for involvement in the cared for patient's care. Written information was available to direct carers to the various avenues of support available to them. If a patient who was identified as a carer went into hospital the practice notified either the district nurses or raised it as a concern in multidisciplinary meetings.

Older patients were contacted by the practice upon discharge from hospital, their needs reviewed and they were offered appropriate support or referral to support agencies.

The practice had a notice board within the main office which showed staff patients who were in hospital, or those who had recently died. Staff told us that if families had suffered bereavement a sympathy card was sent. The card contained practical advice on how to dispose of medicines. Information on support services was also available.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice had set up a shared clinic with a GP and physiotherapist. The physiotherapist was able to support decisions on diagnosis and referrals to secondary care, and expedite the process for MRI scans (Magnetic Resonance Imaging).

- The practice offered extended hours on a Monday morning from 7am and telephone evening appointments for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability. These were usually with either a GP or nurse who had undertaken additional training to meet the needs of this group of patients.
- 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.
- The practice operated a recall system for patients with chronic conditions such as asthma, COPD, cardiac disease, diabetes and chronic kidney disease.
- The practice had a weekly diabetes clinic where patients were seen by either a GP, Dietician or nurse according to their need and outcome of checks completed. Dedicated clinics for other long term conditions were also held.
- A phlebotomy service run by the local hospital was available at the practice.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. The surgery was an authorised Yellow Fever Vaccination centre.
- There were accessible facilities, such as a level access entrance, accessible toilets and dedicated parking. The consulting rooms were on the ground floor.
- The practice website had an option to enlarge the print size.
- The practice was wheelchair accessible with limited parking for disabled patients. All clinic rooms were on the ground floor and there was an accessible toilet.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Translation services were available.
- The practice held stocks of, prescribed and dispensed 'just in case' medicines to manage the pain of patients nearing the end of their lives where they would be otherwise unable to obtain appropriate levels of pain relief urgently.
- The practice had responded to a request from community health professionals to pilot a regular multi-disciplinary meeting within one of the local care homes to discuss the health and care needs of the residents living there.
- The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients were sent a letter inviting them into the practice for their annual review. In some cases the practice proactively visited patients at home for reviews.
- The practice had undertaken significant work with palliative care patients and patients on their multidisciplinary meeting list to establish decisions on preferred place of care and resuscitation wishes. They had worked with other agencies to ensure that patients end of life choices were fulfilled. The practice had completed an audit and found that 96% of patients had achieved their end of life preferences.

Access to the service

The practice was open every weekday between 8am and 6.30pm. Morning surgeries were from 8.30am to 12.30pm and afternoon surgeries from 3.30pm to 5pm. Same day appointments ran to different time schedules as required. Pre-bookable extended hours were offered Monday mornings between 7am and 8am. Book on day evening telephone appointments were available for telephone advice from Monday to Thursday 6.30pm to 7pm. There was a pre-bookable weekend GP/Nurse/Healthcare assistant service, run from Saffron Walden Community Hospital. Appointments were made through the practice.

The School Street branch surgery was open between 8am and 12.30pm, plus Monday and Wednesday afternoons between 3.30pm and 5pm.

Results from the national GP patient survey, published in January 2016, showed that patients' satisfaction with how they could access care and treatment was mostly in line with the local and national averages.

Are services responsive to people's needs?

(for example, to feedback?)

- 71% of patients were satisfied with the practice's opening hours compared to a local average of 69% and the national average of 75%.
- 66% patients said they could get through easily to the surgery by phone compared to a local average of 64% and the national average of 73%.
- 39% patients said they always or almost always see or speak to the GP they prefer compared to a local average of 54% and national average of 59%.

During our inspection we checked to see how long patients would have to wait for the next routine GP appointment and found one could be booked for four days later. We spoke with the practice about access to appointments and they were aware of the data and had taken action to improve. Staff told us that they had trialled a Monday morning walk in service (with the patient participation group involvement) however patients had fed back that they did not like the sit and wait aspect. Following feedback from the NHS Friends and Family test, around the availability of doctors, the practice had recruited two more salaried doctors to meet demand.

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

Listening and learning from concerns and complaints

The practice had 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 as a poster in the waiting area, in the practice booklet and on their website.
- Staff told us that one of their complainants had been asked to be, and now was, a member of their patient participation group.

We looked at 11 complaints received in the last 12 months and found these were dealt with in a timely way, and that there was openness and transparency with dealing with the complaint. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. We saw one example where a patient complaint had led to additional training for new staff due to the way an appointment situation had been managed. The patient received a written apology.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality safe care and promote good outcomes for patients.

- The practice had a mission statement which could be found in the practice leaflet and on their website. Our conversations with staff showed that they followed these standards.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice had considered the future needs of the patient population. They were in consultation with various agencies to ensure that the premises the practice was based in reflected those future needs. The partnership structure was also part of those discussions and considerations.

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, and those of other staff around them. The ability to cover each other's roles, where appropriate, was encouraged and training provided to support this.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained. Weekly reviews took place to identify and plan which areas to focus on to improve outcomes for patients.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. There was staff involvement at all levels in risk identification.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

- The partners told us they prioritised high quality care.
- Staff told us the partners were approachable and always took the time to listen to all members of staff. Staff told us that even if the partners did not initially agree with a proposal they would listen to the reasoning and when appropriate approve the proposal. Staff told us that the practice had developed in a positive way as a result of this engagement.
- Evidence we saw and conversations with staff and the GP partners showed us that staff satisfaction, involvement, development and retention was key to the practice.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty which was evident throughout our inspection. The practice had systems in place to ensure that when things went wrong with care and treatment, the practice gave affected people reasonable support, truthful information and a verbal or written apology

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

- Staff told us the practice held team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- The layout of the building and the position of staff facilities meant that there were opportunities throughout the day for clinical and non-clinical staff to interact and discuss issues informally. We saw evidence of this throughout the day of our inspection.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

Are services well-led?

Good 

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active virtual PPG with members aged from 17 years old to over 85 years old (A smaller core met regularly). For example, outcomes from a patient survey undertaken in 2014/2015 showed that patients were requesting improved access to appointments. The practice reviewed the same day appointments system and started offering bookable appointments on Monday mornings. They also looked at offering more on-line access to appointments.

- Any suggestions or questions which caused staff to consider their processes were immediately used for future planning to improve outcomes.

- The practice had gathered feedback from staff through staff meetings and informal conversations. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The partners told us that they encouraged an ethos of lifelong learning within the practice from the receptionist role to the clinicians. They took pride in being a teaching practice and in their trainees.

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.