

# Forest Practice

## Quality Report

26 Pyrles Lane, Loughton, Essex  
IG10 2NH  
Tel: 020 8504580  
Website: [www.forestpractice.co.uk](http://www.forestpractice.co.uk)

Date of inspection visit: 8 December 2015  
Date of publication: 25/02/2016

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 Forest Practice on 9 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.
- There was an effective system in place for reporting, recording and investigation of significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' individual needs and delivered care in line with current evidence based guidance, with patients and, where appropriate, relatives involvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Information about services was available through a variety of sources and easy to understand.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place. It was evident that staff felt supported by management. The practice proactively sought feedback from staff and patients via the Patient Participation Group (PPG), which it acted on.
- A culture of openness and honesty was encouraged by the partners. The provider and staff were aware of and complied with the requirements of the Duty of Candour.

The areas where the provider should make improvements are:

- Display information about how to complain.
- Consider indicating on policies the date they were written and/or the review date.
- They may wish to consider how they can organise their training records so training and training needs are easily identified.
- Consideration of how staff will be able to identify patients who become acutely unwell in the waiting areas.

# Summary of findings

- Review the security of their prescription printer paper when the consulting rooms are not in use.

**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 and recording significant events. Staff were aware of their responsibilities with regard to this.
- Lessons were shared with the appropriate members of staff, including non-clinical 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, 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 systems, processes and practices in place to keep people safe and safeguarded from abuse. Staff were all aware of these and what action they needed to take.
- There was a risk management system in place.

### 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.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance, such as from the National Institute for Health and Care Excellence (NICE).
- There was a rolling programme for clinical audits to ensure quality improvement.
- Clinical staff had the skills, knowledge and experience to deliver effective care and treatment.
- Although staff told us that non-clinical staff had received training, and in house updates for some training, records were not clear on what the training had involved or when it had taken place.
- There was evidence of appraisals and personal development plans for most non-clinical staff and all clinical staff.
- Staff worked with multidisciplinary teams, such as health professionals involved in the care of children, 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



# Summary of findings

- Data showed that patients rated the practice higher than others for several aspects of care. For example, when asked if the last GP they saw or spoke to was good at listening to them, patients rated the practice higher than the CCG or national average.
- Patients said they were treated with compassion, dignity and respect. They said they were involved in decisions about their care and treatment and had sufficient time during consultations.
- We observed that members of staff were courteous and very helpful to patients and treated patients with kindness and respect.
- When families were bereaved the last GP to see the patient would contact the family.
- Where a patient needed someone to talk to but not necessarily a GP or nurse, reception staff would spend time chatting to that patient in a private room.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice worked closely with other organisations in planning how services were provided to ensure that they meet people's needs. For example, they were actively taking part in several pilots, such as, a shared frailty meeting involving both health and social care professionals.
- Patients comments to us, either on the day or via comments cards left by us, were mixed in response to how easy they found it to make an appointment both with a named GP and for same day urgent appointments. This was reflected in GP satisfaction survey data, published July 2015, which had some areas related to access to the service above the national average and some below.
- We found positive examples to demonstrate how patient's needs were considered when planning duration and location of the individual patient's consultations.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain although available was not displayed in the waiting areas or receptions. However evidence showed that the practice responded quickly to complaints raised and that learning from complaints was shared with staff.

## Are services well-led?

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

Good



# Summary of findings

- There was a clear, publicised vision and strategy to deliver high quality, caring and efficient primary health care for all their patients within a friendly, approachable yet professional environment.
- There was a clear leadership structure. Staff told us that they 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 risk management arrangements and arrangements to review and improve the quality of care provision.
- The provider and staff were aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty which was evident throughout our inspection. The practice had systems in place for knowing about notifiable safety incidents.
- The practice implemented suggestions for improvements and made changes to the way it delivered services, where resources allowed, as a consequence of feedback from patients and from the patient participation group.
- Staff told us they felt able to make suggestions to improve service provision and knew these would be acted upon.
- There was a strong focus on continuous learning and improvement at all levels.

# 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 offered proactive, personalised care to meet the needs of the older people in its population.
- Each care home supported by the practice had a lead GP partner who visited on a weekly basis. All other older patients had a named GP.
- It was responsive to the needs of older people, and offered home visits, where necessary, for flu vaccinations. Home visits were also provided for annual health checks for those older patients with a chronic disease who were unable to attend at the practice.
- The practice was an AGE UK hub for advice and support.
- The practice hosted regular frailty meetings with health and social care professionals invited.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were comparable with other practices nationally. For example, the practice offered patients aged 65 and older a flu vaccination, and performed similar to the national average for uptake of this vaccination.
- The practice tried to ensure that appointments for older people took place in daylight hours to avoid them travelling in the dark.

### 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.
- Nationally reported data showed that most 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 comparable to the national average.
- Home visits were available when needed to monitor patients' conditions.
- The practice provided annual multidisciplinary diabetic clinic reviews.

# Summary of findings

- All these patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For those people with complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Patient reviews were according to individual needs.

## Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a missed hospital appointments and practice appointments.
- Children needing an urgent appointment were offered a same day appointment. If no appointments were available then the child would either be seen as an extra or advice would be sought from the duty GP.
- New mothers were seen for a combined postnatal, child development check and immunisation appointment to minimise the number of times the mother needed to attend the practice.
- A room was made available for breastfeeding mothers who preferred to feed their baby in private.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We found that GPs were aware that some children may have the ability to make decisions about their own treatment.
- Nationally reported data showed that outcomes for patients for uptake of cervical smears were comparable with other practices nationally.
- We saw good 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

- The practice offered extended hours access in the form of pre-bookable appointments from 7am, and book on day appointments from 7.30am.
- Prescriptions could be ordered on line and sent to any chemists of the patient's choosing – including close to their place of work.
- The practice was proactive in offering a messaging service as well as a full range of health promotion and screening that reflects the needs for this age group.

## 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



- The practice held a register of patients with a learning disability. Liaison took place with a community specialist nurse as part of a multidisciplinary approach to their care and treatment. Annual checks were made as extended appointments.
- Where appointments at the hospital or the practice were missed the patient records were routinely reviewed to ensure that no intervention other than a routine reminder letter was indicated. For example, where the patient was a vulnerable child or adult further follow up may be required.
- The practice held a register of patients living in vulnerable circumstances including those at risk or experiencing domestic abuse and those with a learning disability.
- It offered longer appointments for people with a learning disability, where these were required.
- For patients who may find it difficult to be at the doctors, for example, those on the autistic spectrum or those with phobias, the practice put in place measures to minimise distress to those patients on an individual basis.
- 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.
- The practice had shared care arrangements for number of patients with substance misuse problems on their register.

# Summary of findings

- The practice had devised a visual feedback form to enable its patients with a learning disability to provide feedback on their service.

## 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 amount of people diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, was comparable with the national average.
- The practice was in the process of becoming a dementia friendly organisation.
- Patients were sign posted to support services as required, such as, Healthy Minds talking therapies.
- Patients were able to see a named doctor of their choice for continuity of care.
- The practice felt that this population group was an area where they could further improve patient outcomes.
- The amount of people diagnosed with schizophrenia, bipolar affective disorder and other psychosis that had their alcohol consumption recorded in the last 12 months was much lower than the national average.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results published on 2 July 2015 showed a mixed picture with the practice mostly performing in line with local and national averages, but with a few responses above and some below the CCG and national average. 296 survey forms were distributed and 110 were returned.

- 60% found it easy to get through to this surgery by phone compared to a CCG average of 63% and national average of 73%.
- 79% found the receptionists at this surgery helpful compared to a CCG average 85% and national average 86%.
- 83% described their overall experience of using the surgery as good compared to a CCG average of 81% and national average of 84%.
- 87% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average 84% and national average of 85%.
- 91% said the last appointment they got was convenient compared to a CCG average 90% and national average of 91%.
- 79% described their experience of making an appointment as good compared to a CCG average 67% and national average of 73%.

- 68% usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average 58% and a national average 64%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 34 comment cards which were mostly positive about the standard of care received. Patients told us that the practice was clean, that staff treated them with dignity and respect, they felt listened to. Five of the comment cards, whilst still containing positive aspects, commented on areas which they felt could be improved. These areas included telephone access, time delay to see preferred doctor, wheelchair access to get to clinic rooms.

We spoke with 10 patients during the inspection. All 10 patients said that they were happy with the care they received and thought that most staff were approachable, committed and caring. Five patients said that it was difficult to get through to the practice by telephone in the morning to make an appointment. The other five told us that they had no problem with making an appointment in the morning.

## Areas for improvement

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

- Display information about how to complain.
- Consider indicating on policies the date they were written and/or the review date.
- They may wish to consider how they can organise their training records so training and training needs are easily identified.
- Consideration of how staff will be able to identify patients who become acutely unwell in the waiting areas.
- Review the security of their prescription printer paper when the consulting rooms are not in use.

# Forest Practice

## Detailed findings

### Our inspection team

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

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

### Background to Forest Practice

Forest Practice was started in 1977 at premises in Forest Road, Loughton, by a single handed female GP with approximately 300 patients. The numbers of patients and GPs grew over the years and the practice moved in 1990 to Station Road. In 2002 the practice moved again to its current location but retained the Station Road premises as a branch surgery.

The practice currently has a list size of 10146. The practice area covers all of the IG10 postcode area dependent on their capacity.

The practice has two female and two male GP partners and a female salaried GP.

This practice is a training practice which has GP registrars in their final stage of training. GP registrars are fully qualified and will have had at least three years of hospital experience. The gender of the GP registrars will change each intake, however at the time of our inspection there were four female GP registrars. There are two practice nurses and one health care assistant (HCA).

The practice is open between 7am and 6.30pm Monday to Friday. Appointments run throughout the day from 7am. Surgeries are staggered depending on the staffs' differing start times, with morning surgery 2.5 hours in duration and afternoon surgery 2 hours in duration. Between surgeries GPs will complete home visits and other essential tasks.

When the practice is closed there is a doctor or deputy on call 24 hours a day to deal with genuinely urgent problems that cannot wait until the surgery is next open. This service is accessed via the usual surgery number and then a recorded message will give a contact number for patients to ring. The practice also advises patients to attend walk-in centres or, in an emergency such as chest pains, to call 999.

The practice also provides services from their Station Road branch address. This was not inspected as part of our inspection.

### 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 9 December 2015.

During our visit we:

# Detailed findings

- Spoke with a range of staff – including GPs, GP registrars and nursing staff.
- Spoke with patients who used the service and their family members.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed policies and procedures used by the practice in their day-to-day management of the service

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People 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.
- 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 to make sure action was taken to improve safety in the practice. For example, a prescribed medicine was incorrectly dispensed by a community pharmacy, when the patient attended the practice feeling unwell. This was identified by the practice nurse and further action taken to investigate at what stage the error had occurred and whether systems needed changing to minimise the risk of reoccurrence.

When there were unintended or unexpected safety incidents, people received reasonable support, a verbal or 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 people 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. One of the GP partners was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3.
- There were systems in place to identify and follow up vulnerable adults and children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a missed hospital appointments and practice appointments.

- A notice in the consulting rooms advised patients that a chaperone service was available, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (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 clean and tidy. The practice nurse was the infection control clinical lead and provided an in house training session for other staff. There was an infection control protocol in place. Annual infection control audits were undertaken. The latest audit undertaken was a handwashing audit to ensure staff were effectively washing their hands.
- 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 carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice had strong systems in place for ensure that patients taking high risk medications received the appropriate tests and checks to ensure they were receiving the correct dosage.
- Printer prescription paper was not securely stored. We discussed this with the practice who said that they would come up with a system for securely storing these as a priority.
- We reviewed four personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

### 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 with a poster in the reception office. The practice had up to date fire risk assessments and had carried out fire drills. All electrical

## Are services safe?

equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. If staff found equipment was not working they had a system in place to report this. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as health and safety and legionella.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. When staff left the practice the staff mix was reviewed to ensure that the skill mix reflected the needs of the practice.

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

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

- All staff received annual basic life support training.

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice. All the medicines we checked were in date and fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

However, due to the waiting rooms not being visible to reception staff, it was possible that if a patient was alone in one of these waiting areas they could become unwell without practice staff being aware. Staff told us that members of practice staff went into the waiting area from time to time and usually there were other patients in the area. They told us they would review this issue.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice used the intranet system to keep all clinical staff up to date with the latest guidelines.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality 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 91% of the total number of points available, with 5% exception reporting. Exception reporting is where patients are excluded from the performance data. This may be due to the practice being unable to carry out reviews despite inviting patients or treating patients where the treatment is contraindicated. Data from the year 2014 to 2015 showed;

- Performance for assessing and treating patients with diabetes was in line with national average for some indicators and worse for others. 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 84% with a national average of 88%. 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 similar to the national average. 80% for the practice compared to 83% national average.
- Performance for mental health related indicators was similar to the national average in most areas. However, this practice had a large variation in the data for one of the clinical indicators for patients with a mental health diagnosis. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been

recorded in the preceding 12 months was 64% compared to national average of 89%. The practice acknowledged that they needed to improve outcomes for this patient group.

- Performance for the percentage of patients diagnosed with dementia who received an annual review was comparable with the national average. 82% for the practice compared to 84% national average.

Clinical audits demonstrated quality improvement.

- There was a lead GP for audit and over 10 clinical audits had been undertaken in the last two years. Not all of these were completed audits; those that weren't were on a rolling programme. Where there was a second cycle completed the improvements required were implemented and monitored.
- Findings were shared in meeting and used by the practice to improve services. For example, recent action taken as a result included an audit summary being given to all the GPs at the practice following a medicines audit. This was to highlight the outcome of the audit and improve prescribing habits and potential safety risks to patients. Patients prescribed the medicines were being contacted in order to discuss their prescription and dosage. The GPs were either reducing dosages or inviting patients in to discuss further.

### Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff however not all staff files contained copies of this information so staff had to search to find evidence that this had taken place.
- There was no training plan so it was difficult for the practice manager to easily show what training staff had received and when updates were due. However it was evident from conversations with staff that some training had taken place and staff had knowledge of the topics learned.
- The practice had a relatively new practice nurse in place who had just been made responsible for completing annual reviews for patients with learning disabilities. The practice nurse told us that they would benefit from more training and support.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice



# Are services effective?

## (for example, treatment is effective)

development needs. Staff had access to appropriate training to meet these 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 the revalidation of doctors. All staff except one of the secretaries had had an appraisal within the last 12 months.

### 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. Information such as practice specific patient information leaflets were also available.
- The patient record system alerted staff to children and adults who had been identified as being vulnerable.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.
- The practice gave us an example where they kept in touch with a patient's nominated next of kin by email as the person lived overseas.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. For example, the practice maintained a register of patients with a learning disability that they cross-checked with the community nurse practitioner for learning disabilities.

The practice offered a drugs and alcohol service via a shared care system with Open Door. Open Door is a registered charity that provides support for individuals affected by drugs and alcohol across Essex and Suffolk

The practice had a named health visitor who would attend the beginning of clinical meetings to make sure that information about children requiring support from the practice, health visitors or both was shared. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

### 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. Staff were able to give us examples of situations when they had done 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, where appropriate, recorded the outcome of the assessment.
- For minor surgery and insertion of intrauterine contraceptive devices written consent was requested and recorded.

### Health promotion and prevention

The practice identified patients who may be in need of extra support. These included patients requiring advice on their diet, smoking and alcohol cessation.

- Patients were signposted to relevant service and support agencies to meet their needs.
- Smoking cessation advice was available and the practice ran reports to view progress on the success of the programme.
- When patients with a long term condition, such as, heart failure or ischaemic heart disease attended for their annual review they were screened for depression.
- The practice aimed to review all patients with a long term condition after a hospital admission.
- The practice had started a programme where nurses weighed patients as they came in for appointments so that if a patient attended the practice complaining of weight loss they would have a comparison weight.

The practice had a system for ensuring results were received for every sample sent as part of the cervical screening programme. The practice's uptake for the cervical screening programme was 76%, which was comparable to the CCG average of 76% and the national average of 74%.

# Are services effective?

(for example, treatment is effective)

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

- The percentage of childhood 'five in one' Diphtheria, tetanus, pertussis (whooping cough), polio and flu immunisation vaccinations given to under one year olds was 95% compared to the CCG percentage of 95%.
- The percentage of childhood Mumps Measles and Rubella vaccination (MMR) given to under two year olds was 88% compared to the CCG percentage of 94%.

- The percentage of childhood Meningitis C vaccinations given to under five year olds was 98% the same as the CCG percentage of 95%.
- Flu vaccination rates for the over 65s were 66%, and at risk groups 40%. These were also comparable to national averages (73% and 47% respectively).

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

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people kindness, 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 and that conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 34 patient CQC comment cards we received were positive about the service experienced. Most patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

We also spoke with a member of the patient participation 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 were caring and provided support when required.

Results from the national GP patient survey, published on 2 July 2015, showed patients felt they were treated with compassion, dignity and respect. The practice was above average for most of its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 87% and national average of 88%.
- 89% said the GP gave them enough time compared to the CCG average of 83% and national average of 86%.
- 95% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.
- 84% said the last GP they spoke to was good at treating them with care and concern compared to a CCG average 81% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to a CCG average of 88% and national average of 90%.

However, for some of the satisfaction scores relating to overall experience, access to preferred GP and helpfulness of reception staff the scores were lower than average. For example:

- 79% said they found the receptionists at the practice helpful compared to a CCG average of 85% and national average of 86%.
- 52% of patients with a preferred GP said they usually don't get to see or speak to that GP, compared to a CCG average of 46% and national average of 40%.

The practice told us that they were in the process of becoming a 'Dementia Friendly' organisation. This would enable them to provide better support to those patients with dementia and their carers and highlight the issue to the patient population generally. The Dementia Friendly Communities programme is headed by the Alzheimer's Society and focuses on improving inclusion and quality of life for people with dementia.

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

Patients told us that 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 all except one 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 or above local and national averages. For example:

- 89% 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%.
- 79% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 81%.

Staff told us that longer appointments were offered to those patients who did not have English as their first language. Translation services were available for these patients.

The practice encouraged older patients and, where appropriate, their families to be involved in decisions on

## Are services caring?

the management of their health. Patients with a long term condition such as diabetes or COPD (chronic obstructive pulmonary disease) were supported by the practice to self-manage their symptoms. For example, patients with COPD were encouraged to have rescue packs and given a personalised self-help leaflet.

Each care home supported by the practice had a named lead GP partner who visited on a weekly basis to provide continuity of care. All older people also had a named GP, although they may see other GPs at the practice for urgent appointments.

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

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

The practice's computer system alerted GPs if a patient was also a carer. Carers were identified through the new patient

registration form, when patients attended for reviews of their long term conditions or when reviewing those at risk of hospital admission. Carers, including young carers, were given a needs assessment, and sign posted to the various avenues of support available to them. If required the practice would also refer on to Social Services. The practice did this for all identified carers regardless of whether the person they cared for was registered at the practice. When the practice sent out invites for flu vaccination clinics they used the computer system to identify carers and invited them to receive a flu vaccination.

Staff told us that if families had suffered bereavement, the last GP to see the patient would telephone the family and act as a point of contact for them.

When patients needed someone to speak with but did not necessarily need to see a GP or a nurse, reception staff would spend time chatting to with them in a side room.

# 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 Clinical Commissioning Group (CCG) and other relevant organisations to secure improvements to services where these were identified. For example, they were actively taking part in several pilots such as a shared frailty meeting involving both health and social care professionals. The practice was also an AGE UK hub for advice and support.

- The practice offered extended morning hours Monday to Friday from 7am for working patients and those who may find it difficult to attend during normal opening hours. The first half hour of appointments were pre-bookable up to four weeks in advance, both by phone and online. The next hour were bookable on the day appointments.
- The length of time required for an appointment was according to patient need. If a patient required a longer than usual appointment slot as standard, a note would be made on the patient record so that reception staff were aware and could book the patient's appointments accordingly.
- Patient's individual needs were also considered when planning other details of the appointment. For patients who may find it difficult to be at the doctors, such as, those on the autistic spectrum or those with phobias, the practice put in place measures to minimise distress to those patients on an individual basis. For example, if a patient would find waiting in the waiting area overwhelming the practice would consider the timing of the appointment or the area that the patient was waiting in.
- Annual checks for patients with a learning disability were longer than usual appointments. Contact to arrange to annual check was made with either the patient or their carer (whichever was appropriate for the patient).
- Home visits were available for older patients / patients who would benefit from these, including annual health checks, where the patient would be unable to attend the practice.

- The practice tried to ensure that all appointments for older people took place in daylight hours to avoid them having to travel in the dark, which may be more difficult due to eyesight or mobility.
- Same day appointments were available for children. If no appointments were available then the child would either be seen as an extra or advice would be sought from the duty GP.
- New mothers were seen for a combined postnatal, child development check and immunisation appointment to minimise the number of times the mother needed to attend the practice.
- The practice provided multidisciplinary diabetic review checks so that the patients could have all the necessary checks completed in one visit.
- Prescriptions could be ordered online and sent to any chemist of the patient's choosing – including close to their workplace.
- There were lifts available in the building and an accessible toilet however the lift door was quite heavy and some patients needed staff assistance to open this. Patients who were unable to open the front door themselves used a doorbell to alert staff who would then assist them into the building. The practice had researched costs for installing an automatic door however had been unable to proceed due to financial restraints, therefore had initiated this alternative.
- Where patients were undergoing or had undergone treatment for gender reassignment, the practice policy was to treat patients according to the gender they identified with, and preferred name.

### Access to the service

The practice was open between 7am and 6.30pm Monday to Friday. Appointments ran throughout the day from 7am. Surgeries were staggered depending on the staff members' differing start times, with the morning surgery 2.5 hours in duration and the afternoon surgery 2 hours in duration. Between surgeries GPs would complete home visits and other essential tasks.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable or higher than the local and national averages, with the exception of ease of access to the practice by phone which was lower.

Patients told us on the day that they were usually able to get appointments when they needed them. Although two

# Are services responsive to people's needs?

## (for example, to feedback?)

patients told us that due to length of time to get through to the practice by telephone in the morning, the time that they were given for an appointment was sometimes no longer convenient. The practice told us that they had completed opinion polls with the patients regarding opening times and access to appointments and also tried different ways of working to overcome this issue. The current system was set up as a result of this work.

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 68% and national average of 74%.
- 60% patients said they could get through easily to the surgery by phone (CCG average 63%, national average 73%).
- 68% patients described their experience of making an appointment as good (CCG average 58%, national average 64%).
- 68% patients said they usually waited 15 minutes or less after their appointment time (CCG average 58%, national average 64%).

The practice emailed and sent text messages to patients, following appointments or investigations, where this was the most appropriate method of communication for that person.

### Listening and learning from concerns and complaints

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

- The 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 could not see information displayed to help patients understand the complaints system, although there was a complaints leaflet held by reception staff. The practice told us that this was an oversight and that a poster and leaflets were usually in the waiting area, but may have accidentally been moved to make way for new posters.

We looked at eight complaints received in the last 12 months and found they were dealt with in a timely way. There was openness and transparency with dealing with the complaint. Complaints viewed stated that the aside from the specific complaint incident the care received by the practice was good. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, there was a complaint regarding a missed recall for a contraceptive device. The complaint was investigated and found to be due to changed national guidelines. The practice recalled other patients this issue may have affected and updated protocols to ensure the likelihood of a recurrence was minimised.



# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

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

The practice had a mission statement which was displayed on the website. The practice statement of purpose stated their aim was to provide high quality, caring and efficient primary health care for all their patients within a friendly, approachable yet professional environment. Their statement of purpose went on to say they constantly strove to review and improve the services they offered and continually investigate new services to better meet their patients' needs.

### 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 leadership structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff. Although these were not dated with either creation or review date, which is helpful for staff to ensure they are reading the latest version.
- There was a comprehensive understanding of the performance of the practice throughout the clinical team. For example, the practice were aware that their performance with regards to outcomes for patients with mental health conditions was not as good as it could be and were looking to improve outcomes for this group of patients going forward.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. Management tasks related to the day to day running of the practice were divided out between the partners and outsourced where they did not feel they had the expertise.

The partners has monthly meetings where they could discuss the practice and any issues. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff.

The provider and staff were aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty, which was evident throughout our inspection. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents the practice gives affected people reasonable support, truthful information and a verbal and written apology.

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

- Staff told us that the practice held regular team meetings.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, had confidence in doing so and knew that action would be taken.
- 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. Staff were able to give us examples of where improvements suggested by them had been implemented.

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

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.

- It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. Regular PPG meetings took place which a representative from the practice team attended. Issues raised by the PPG were noted by the practice and where financially viable changes were made. Where changes could not be made the practice

# Are services well-led?

Good 

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

considered with the help of the PPG how they could mitigate the impact of the issue. For example, the doors of the practice are not accessible and the practice could not support the cost of an electric door therefore they had instigated an alternative whereby patients could ring the bell and staff would assist the patient in accessing the premises.

- The practice had viewed the data from the 2014 GP patient survey around availability of appointments and completed their own analysis of appointment use to improve patient access to the practice.
- The practice had devised a visual feedback form for their patients with a learning disability to enable them to provide feedback too.

- The practice had also gathered feedback from staff through staff meetings, appraisals. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice.

The practice manager liaised with other practice managers within the area to improve the service and learn from each other. Some of the areas we identified for improvement during our inspection had already been identified by the practice and changes made as a result. Whilst they acknowledged that they had not got some things quite right, they had not stopped seeking solutions.