John Tasker House Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at John Tasker House on 02 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for the 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 and people experiencing poor mental health (including people with dementia).

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

- Staff knew how to report significant events and we found that action had been taken in response to safety alerts. Actions were also taken following investigations into significant events, although these were not always reviewed to assess their impact.
- The practice worked with other agencies to help ensure the care and support provided to vulnerable children and adults was coordinated and effective.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice had taken action to improve performance in areas such as the care of patients with diabetes, including through staff training.
- Staff were aware of how to support patients whose capacity to understand and make decisions may be limited, for example for patients who had dementia.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Complaints were dealt with appropriately and in a timely manner.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted upon.

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

Summary of findings

Importantly the provider should:

- Introduce a system whereby changes made as a result of investigations are reviewed to determine their effectiveness.
- Review the arrangements in the dispensary to ensure medicines prescribed are dispensed promptly to patients.
- Take steps to improve the take up of annual health checks of people with a learning disability.
- Ensure all clinical audits are completed audits.
- Record minutes of all meetings that are held including both the nurses and clinical meetings.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff knew how to raise concerns, and to report incidents and near misses. Lessons were learned and changes were made to improve practice. The practice did not always review these changes to determine their effectiveness. Staff had undertaken training in safeguarding children, and there were arrangements in place to effectively respond to any safeguarding concerns, including domestic abuse. This was supported through multi disciplinary working with partner agencies. There were enough staff to keep patients safe. Arrangements were in place to respond to medical emergencies.

Are services effective?

Good

The practice is rated as good for providing effective services. Where data showed patient outcomes were below the average for the locality, the practice had taken action to improve services in these areas. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Nobody with a learning disability had taken up the offer of an annual health check in the preceding 12 months, and with only two scheduled in the immediate future this was an area where the practice was considering the action they needed to take to improve. Staff had received training appropriate to their roles and any further training needs had been identified. There was evidence of appraisals and personal development plans for staff.

Are services caring?

Good

The practice is rated as good for providing caring services. The patients we spoke with were positive about the care they received, and reported feeling respected and listened to by staff. We saw that staff treated patients with kindness and patient confidentiality was maintained. In the National GP Patient Survey 2015 the practice performed above the Clinical Commissioning Group average for patients feeling that the GP involved them in decisions about their care, and the GP was good explaining tests and treatments to them. This was supported by the patients we spoke with during our inspection, and by other professionals with whom we spoke. There were arrangements in place to support people who had had a bereavement.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. There were mixed views amongst patients about accessing appointments. The National GP Patient Survey 2015 found that this was an area in which the practice performed less well than the Clinical Commissioning Group average. The practice's patient survey found that only 11% of patients were aware of the online appointment booking system, and this was an area in which the practice was raising patient awareness. The practice adapted its access arrangements for those who had limited telephone access to either make an appointment or to use the triage arrangement in place. Representatives of care homes with whom we spoke reported that the GPs were responsive to the needs of people living in the respective home. The practice was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a patient charter which encompassed a vision to provide a high quality service. There was a clear leadership structure and staff felt supported and valued by management. The practice had a number of policies and procedures to govern activity and held a range of clinical and staff meetings. There were systems in place to monitor and improve the quality of services using data available. The practice proactively sought feedback from staff and patients through the use of suggestion boxes. The practice acted upon this feedback. The Patient Participation Group (PPG) was active, and members we spoke with told us they felt valued.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Patients over the age of 75 years had a named GP, and there was a nominated GP for each of the five care homes in the practice area. The practice had identified the most vulnerable 2% of its older population and had care plans in place. Home visits were available and the practice nurses visited care homes to provide flu vaccinations. The practice held multi disciplinary meetings to ensure the care provided to older people was coordinated with other care providers. The practice maintained a frailty register which it regularly updated following these meetings.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice worked with and was responsive to partner agencies to ensure care was co-ordinated. Appointments were available outside of school hours and the premises were suitable for children and babies. Childhood immunisation rates were in line with the Clinical Commissioning Group average, and the practice offered a six week check for new babies. Staff were aware of the Gillick competencies which are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. The practice provided free condoms to young people under the age of 20.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The practice provided appointments between 6.30pm and 7.30pm two evenings

Summary of findings

a week which were useful to patients who were unable to attend during the working day. The practice, following feedback from its own patient survey, had taken recent action to increase awareness of their online appointment booking system. The practice offered a family planning clinic which was open to both registered patients and others who were not registered at the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients who had a learning disability and offered annual health checks to this group of patients. The practice was considering ways in which patient take up of these checks could be improved. The practice was responsive to the needs of its traveller community and aware of those patients who may be homeless. Staff at the practice, were aware of the arrangements in place to safeguard their patients, and how to respond to concerns. Information about how to access support services was available in the practice.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with mental health needs were invited for annual reviews. The practice's performance in diagnosing patients with dementia was above the national average. The practice worked with multi-disciplinary teams to support people experiencing poor mental health including those with dementia. The practice was improving its arrangements to review the needs of patients with dementia through increased staff training. Information about MIND was available in the patient waiting room.

Summary of findings

What people who use the service say

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 32 cards that had been left for us and reviewed the comments made.

The majority of patients who completed the cards were positive about their experience of the care they received at the practice. Comments were mainly positive about the staff, referring to both their kindness and helpfulness. Those who commented reported that they felt they were listened to and involved in decisions about their care. Where patients we received less positive comments these related to the appointment system. These comments included the wait, up to three weeks, for a non-urgent appointment, particularly if the appointment was with the same GP to ensure continuity of care, and the length of the appointment. Patients reported that they found the practice was clean and hygienic.

We spoke with eight patients on the day of our inspection; this included three patients who were members of the Patient Participation Group. (A Patient Participation Group is a group of patients registered with a practice who work with the practice to improve services and the quality of care.) They told us that they were overall happy with the service provided at the practice. Patients told us that they could get an emergency appointment, although one patient commented that the practice was not open at the weekend and that the triage system at the main surgery was a telephone triage. Some patients told us that they could wait a week or two to get a non urgent appointment, whilst others that they felt it was relatively easy to get a non urgent appointment. Patients told us that they felt listened to, and that the staff were helpful. We were told that the arrangements in place for referrals to and liaison with secondary care services worked well.

We spoke with representatives of three care homes in the area; people living in these care homes received their primary medical service from the practice. Overall we received positive comments about the support provided by the GPs, and how they related to people living in the care home. We were, however, told that sometimes the medicines prescribed were not always available at the dispensary when expected.

The representatives of the Patient Participation Group (PPG) with whom were spoke told us that they felt the practice both listened to and acted on their views. They told us that they were involved in discussions about action the practice could take in response to suggestions made by patients using the suggestion box available for patients. We did receive comment that the PPG would like more involvement in complaints received by the practice.

The NHS Friends and Family test (FFT) had recently been introduced at the practice. The most recent findings reflected that all those patients who completed the FFT would recommend the practice to others.

Areas for improvement

Action the service SHOULD take to improve

- Introduce a system whereby changes made as a result of investigations are reviewed to determine their effectiveness.
- Review the arrangements in the dispensary to ensure medicines prescribed are dispensed promptly to patients.
- Take steps to improve the take up of annual health checks of people with a learning disability.
- Ensure all clinical audits are completed audits.
- Record minutes of all meetings that are held including both the nurses and clinical meetings.

John Tasker House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector**.** The team included a GP, a practice nurse and a practice manager.

Background to John Tasker House Surgery

John Tasker House Surgery is situated in the town of Dunmow in Essex. The practice has a branch surgery in the nearby town of Felsted; at The Surgery, Braintree Road, Felsted. We did not visit the branch surgery as part of this inspection. The practice has a population of 13800 patients and encompasses those who live on a traveller site.

The practice team comprises five GP partners and five salaried GPs, providing the full time equivalent of 7.25 GPs. The practice has both male and female GPs. In addition the practice is a training practice and accommodates GPs who are in training. There is also a team of five nurses and a healthcare assistant. There are practice managers at both the Dunmow surgery and the Felsted surgery, as well as a team of administrative staff.

The practice has a dispensary, staffed with dedicated dispensary staff, at both its surgeries.

The practice is an accredited research practice.

John Tasker House holds a General Medical Services Contract to provide primary medical services. The practice has opted out of providing out of hours services.

The practice was last inspected in December 2013 and was not found to be in breach of the regulations in force at that time.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

How we carried out this inspection

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

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

Detailed findings

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)

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 02 April 2015. During our visit we spoke with a range of staff, including doctors, nurses, administrative and dispensary staff. We also spoke with patients who used the service, and members of the practice's Patient Participation Group. We reviewed the policies, protocols and other documents used at the practice. Before we visited we provided comment cards for patients to complete about their experiences at the practice. We received 32 completed comment cards which we reviewed as part of this inspection. We also spoke with representatives of care homes in which people who use the GP practice lived. We also spoke with representatives of partner agencies to gain their views of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Clinical meetings, although not routinely minuted, were used to discuss safety alerts for example National Patient Safety Alerts (NPSA) and Medicines and Healthcare Regulatory Authority (MHRA) alerts. Although there was no written procedure we were informed that the dispensary manager dealt with medicine alerts by undertaking searches of electronic patient records. We were provided with an example of a recent alert and the action taken. We found evidence to support action was taken by the practice in response to any safety alerts received. Staff we spoke with confirmed that safety alerts were received by email and paper copies of the alerts were also provided. Staff also confirmed that alerts were discussed at the clinical meetings.

Staff we spoke with knew how to report significant events, and we saw records of those which had been reported since 2007. We found significant events were discussed at significant event meetings. Staff we spoke with confirmed significant events were discussed at these meetings, although two administrative staff with whom we spoke could not recall any significant events from which they learnt. We saw minutes of these meetings for October 2014 and February 2015, as well as a summary of significant events for 2014/2015.

Staff we asked were able to tell us about a recent safety alert and a recent significant event.

Learning and improvement from safety incidents

The practice had a system in place for the reporting and recording of significant events. Staff completed forms using the practice intranet site. We saw a summary of the 16 reported significant events for 2014/2015. There was evidence that significant events were logged and investigated. For some significant events we found that there was evidence of learning, a change in practice and a date for further review of the changes. For example we found an error in dispensing medicines had resulted in a change in practice, and this change was scheduled for a further review.

We found an example of a complaint received by the practice that had been dealt with as an urgent significant event.

However there were no review dates for some changes in practice following investigation into a significant event. Furthermore, where review dates had been recorded there was no evidence that the change in practice had been reviewed. This was confirmed by staff in our discussion with them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Safeguarding procedures, including both domestic abuse, and sexual abuse procedures, were available to staff. Contact details of key staff in partner agencies were available in the consultation/treatment rooms. The practice also had a lead GP for both safeguarding adults and for safeguarding children. During our inspection we saw the lead GP for safeguarding provide advice and guidance to a colleague on the actions to take in the event of a concern that had very recently arisen. Staff we spoke with were aware of actions they would take if they had safeguarding concerns, and knew who was the lead person for safeguarding in the practice. Reception staff we spoke with said that if a patient attended for an appointment, and they were concerned they would put an alert on the system for the GP to note when they saw the patient.

The lead GPs for safeguarding in the practice were trained to the appropriate level. All of the nursing staff had received training in child protection to level 2/3. The dispensary staff and the majority of the administrative staff had also undertaken e-learning in children protection. At the time of our inspection staff were undertaking training in adult safeguarding.

Where there were concerns related to children's safeguarding these were noted on the patients' records. Multi disciplinary safeguarding children meetings took place six weekly, with any updated information recorded contemporaneously on the patient's own records. The lead GP for safeguarding told us that these meetings were helpful in identifying shared concerns or matters to which they needed to be alert. The practice received all reports related to domestic violence. The lead GP for children's

safeguarding told us that if they had specific concerns about safeguarding arrangements they would liaise with either the GP or nurse safeguarding lead at the Clinical Commissioning Group.

The practice monitored children's attendance at the accident and emergency department, and liaised with the health visitor to determine an appropriate response. The practice also monitored concerns, for example related to the take up of childhood immunisations of children within a family.

The practice had a chaperone policy which included details as to who could chaperone and action to take if a chaperone was not available. The policy also reflected considerations needed in respect of a person's ethnicity, sexual orientation, culture and mental health needs for example. Nine members of the staff in the administrative team had been trained as chaperones. Information about the availability of chaperones was available in the practice waiting room.

Medicines management

The practice was also a dispensing practice, and a dispensing protocol dated February 2015 was available to staff. Patients could order repeat prescriptions in person or on line. The dispensary staff checked the name of the patient, their date of birth and how many times the medicines had been dispensed before requesting a GP authorise the repeat prescription. The dispensary staff confirmed that they did not issue a repeat prescription without the authorisation of a GP. The practice undertook audits of medicines that had not been collected by patients.

We were informed by two care home representatives that sometimes medicines prescribed were not always dispensed promptly by the practice's dispensary, and that the care homes were not always informed when the medicines were ready for collection. We were informed that the arrangements for managing prescriptions for people living in the care homes worked well.

There were systems in place for the stock control of medicines. A scanning system was used to generate orders of medicines for the practice. The expiry dates of medicines were routinely checked, and out of date medicines were disposed of appropriately. The practice dispensary also disposed of medicines issued by other pharmacies in some circumstances, for example for older patients. The dispensary did not label the container of out of date medicines but agreed to do this at the time of our inspection. Any out of date controlled drugs (CDs) were kept in a locked cupboard. (Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.)

We found the key to the vaccines fridge was accessible to staff and patients. This was addressed by the practice at the time of our inspection to ensure vaccines were securely kept. Any controlled drugs were kept securely and with limited staff access. We checked the stocks of controlled drugs and found that the amounts available tallied correctly with the corresponding records. Emergency medicines were kept in the GPs' bags and other than through the prescription pads there was no record of what had been used. There was an audit trail for the use of prescription pads, and blank prescription pads were kept securely.

There was twice daily recording of the temperature of the room in which the medicines were kept. Records were also kept of the temperature of the fridge in which vaccines were stored. Temperatures were within the required temperature range. A deep clean of the dispensary was undertaken every six months.

A canister of nitrogen was kept at the practice, and shared with the branch surgery and a neighbouring practice in the locality. Staff confirmed that they had available the correct container for the safe transportation of the nitrogen if and when this was required.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control.

The practice had an infection prevention and control policy. We saw infection control audit had been undertaken in July 2013 by a company independent of the practice. The audit identified actions required of the practice and we found action had been taken in response to the audit.

Both the branch and main surgery had a lead in infection prevention and control. One of these members of staff had received infection prevention and control training in the

last two years. Both were due to attend further training in June 2015. Other staff received role specific training in infection prevention and control, and there were plans to include this in the induction policy.

We found that each treatment room had a cleaning schedule, and the practice employed a cleaner. Although the cleanliness of the treatment rooms was checked, these checks were not recorded.

The hand gels available on the day of our inspection were in date, and spillage kits were available. The curtains in the consultation and treatment rooms were changed every six months. A waste management contract was in place.

A legionella risk assessment was scheduled for the end of March 2015. No previous legionella risk assessment had been carried out at the practice. (Legionella is a term for a particular bacteria which can contaminate water systems in buildings and can be harmful.)

Equipment

We saw that portable appliance testing took place at the practice and all equipment had been tested as required. We also found that equipment was calibrated. Sufficient equipment was available for staff to enable them to carry out diagnostic examinations. There was a full canister of oxygen available at the practice. We found the examination couches were in a good state of repair.

Staff we asked confirmed that all the equipment they needed was available.

Staffing and recruitment

The practice had a recruitment policy but this did not include the checks to be taken up on staff prior to starting work. We checked the recruitment files of two of the most recently recruited staff, and found that generally appropriate recruitment checks had been undertaken prior to employment. For example proof of identification and references. Criminal records checks had been carried out through the Disclosure and Barring Service (DBS). We were informed that all clinical staff and any non-clinical member of staff who had contact with patients had been subject to a criminal records check, and that this was being introduced for all staff in the practice. Health checks/ declarations had not been carried out on staff although records were kept of hepatitis B vaccinations of all clinical staff. This included when the vaccination was next due.

When needed locum GPs were recruited through an agency. The practice received, from the agency, copies of the checks carried out on any locum GP for example their criminal records check, their CV, medical registration information and insurance details.

There was evidence that the practice maintained staffing levels to meet the needs of its patient population. For example more staff had trained in the care of patients with diabetes to meet the increased need. The practice was also increasing its GP capacity in September 2015 to meet the needs of the growing population in the local area. There were arrangements in place to manage staff absences.

Monitoring safety and responding to risk

The practice had a health and safety statement policy which set out the responsibilities of the provider and staff in ensuring the health, safety and welfare of patients, staff and any others on the premises. A health and safety risk assessment had not been undertaken, although a Health and Safety Law poster was displayed. The practice had a lead member of staff for health and safety. We noted that confidential waste, which included patient information, was stored under the stairs and in an area that was accessible to the public.

An accident book was in place and the last entry was dated June 2014.

Staff we spoke with were aware of the actions to take in the event of a medical emergency at the practice. For example two members of staff we asked said that if a patient who felt suicidal attended the practice they would immediately alert the triage doctor. We were also given an example of a time when reception staff had called an ambulance for a patient who was in pain and had phoned the practice. Two reception staff we spoke with knew how to recognise a patient with low blood sugar levels, and said that they would refer them to a GP as soon as possible. A representative of a care home told us that the GPs responded promptly if a person living in the home became acutely unwell.

We were given an example by a patient we spoke with of when they had attended the practice for an appointment with their relative. They said that their relative, due to their medical condition, was immediately sent to hospital and they were provided with a copy of their notes to take with them.

Good

Are services safe?

The practice had identified that they would benefit from developing a risk register and planned to address this.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These included lack of access to the premises, loss of electricity or gas supplies, failure of the IT system and loss of medical records amongst others.

A fire risk assessment had been undertaken. Fire safety equipment was available and maintained.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses were familiar with current best practice guidance for example with guidance from the National Institute of Care and Health Excellence (NICE) which was discussed at clinical meetings which were attended by all clinicians at the practice. Guidance was disseminated to staff both electronically and as a hard copy. Areas of specialism were led by different clinicians in the practice, for example a lead GP for long term conditions.

New patient healthcare checks were carried out as were checks for people with learning disabilities and for those with mental health needs. All patient hospital discharge letters were seen by the GPs. The practice was in line with the national average for the proportion of patients attending accident and emergency departments. We were informed that GP referral letters to other services were usually passed to the administrative staff the same day the patient was seen. Due to an absence of a member of staff at the time of our inspection, the letters were taking two to three days to be processed unless they were urgent in which case they were completed the same day.

The practice referred to data to monitor their performance, for example to improve its performance in blood pressure control in patients with diabetes. The practice responded to the data by training more nurses in diabetes care, and reviewed their diabetic clinics to provide an additional clinic and more appointments each month.

We were told that all referrals of patients were discussed with a colleague at the practice to ensure the referral was appropriate and to discuss alternative approaches. The practice took part in peer review meetings with the local Clinical Commissioning Group. At these meetings different practices presented cases for discussion and to share learning.

We found that medicines were prescribed for patients based on need regardless of cost.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need. For example reception staff told us people who were homeless and without an address were able to register with the practice. It was evident that staff in the practice used the multidisciplinary meetings to gain a full understanding of the needs of their patients.

Management, monitoring and improving outcomes for people

The practice undertook audits to monitor and improve outcomes for patients.

In 2012/13 the practice undertook an audit of the treatment of patients who had had a stroke. This audit followed guidance issued by the National Institute for Care and Health Excellence (NICE). In commencing the audit the practice liaised with the stroke team at the local hospital to also understand their approach to the care of patients who had had a stroke. This audit was completed and showed an increase in the number of patients whose treatment was in line with the NICE guidance. It was also evident that the practice had written to those patients included in the audit to explain to them the action the practice was taking and why.

In January 2015 the practice undertook an audit of patients prescribed vitamin B12 who should attend for regular treatment. The outcome of the audit was a recommendation that the practice introduce a formal recall system for patients requiring vitamin B12. The practice planned to undertake a further audit in a year's time.

We reviewed a number of medicines management audits that had been carried out at the practice. An antibiotics audit included data collected over a period of seven months and an agreed action plan. This audit, at the time of our inspection, had not been completed. We found an audit for hypnotic medicines had commenced with some data collection however the data collection and audit had not been completed.

We were told that audits of minor surgery were undertaken by individual GPs. This was in line with their registration and national guidance.

The practice had a protocol for repeat prescribing, which could be done by the patient online or in person. The protocol included a review of the number of times the medicines had previously been dispensed.

The practice was aware of areas in which performance could be improved, for example in the take up of annual health checks by patients who had a learning disability. The

Good

Are services effective?

(for example, treatment is effective)

practice had taken action to improve performance in areas such as the care of patients with diabetes, and patients with hypertension. This was as a result of benchmarking of their performance against the national average. The practice's performance was in line with the national average for the percentage of patients over 65 who had been given a flu vaccination, the percentage of women who had attended for a cervical screening test, the rate of diagnosis of dementia, and the number of emergency admissions to hospital. The practice had recently introduced a system of monthly performance monitoring to help ensure patients received the best care. We found that the Quality and Outcomes Framework (QOF) had been discussed at staff meetings within the practice. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.)

Effective staffing

Practice staffing included medical, nursing, dispensary and administrative staff. The practice had a practice manager at both the main and branch surgeries and also employed an IT manager. At the time of our inspection the practice had two GP partners, three salaried GPs, a locum GP and a GP registrar. (A GP Registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice.) One of the GP partners was, at the time of our inspection, on an extended break for 12 months and their role was being filled by a salaried GP. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice employed five practice nurses, and the practice manager informed us that they undertook regular checks on the status of the nurses' registration with their professional body; the Nursing and Midwifery Council.

Staff appraisals took place, and those of the administrative staff were carried out by the practice manager and one of the GPs. The GPs undertook the appraisals of the nursing staff. Although the appraisals of the nurses included a personal development plan, action to address this was not always evident. Staff training was based on need, and also to support outcomes for patients. We found the nurses worked within their scope of practice, and were provided with study leave as part of their contract. For example the nursing staff had undertaken further training in the care of patients with diabetes in order to improve care of patients in this area. Another nurse was undertaking training in mental health in order they could carry out reviews of patients who may have dementia. Until they were fully trained in this area, they would not undertake this role. The health care assistant was supervised by a GP in the administration of flu vaccines, and was mentored by the lead practice nurse.

There was evidence that staff were given feedback on their performance and areas for development.

Nurse meetings took place but these were described as informal and not minuted. One of the GPs was the clinical supervisor to the nurses, but staff told us that they could go to any GP with queries.

The locum and GP Registrar confirmed that they had had an induction when they started work at the practice. An induction pack was available to new medical staff on the practice's computer system. This included the organisational structure, a staff list including roles, the code of conduct including confidentiality and safeguarding arrangements.

Staff had access to online training as well as attendance on training courses. The training records we viewed showed that few staff had undertaken training in safeguarding vulnerable adults.

Where there were concerns about performance of staff this was addressed.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Any letters that were received by post were scanned in to the practice system on the day of receipt, and distributed electronically to the GPs.

Good

Are services effective?

(for example, treatment is effective)

If a GP was absent, any incoming letters and results would be reviewed by a colleague GP. The expectation is that the GPs reviewed the letters and test results for their patients by the end of the day they were received.

The practice held monthly multidisciplinary team meetings to discuss adult patients with complex needs, those who were frail and patients who had attended accident and emergency or who had had contact with the out of hours service. These meetings were attended by the community matron, and social worker. In addition the practice held monthly palliative care meetings with the district nurse, end of life care co-ordinator and a representative from the local hospice. Regular multi-disciplinary meetings were also held to share information about children of concern or at risk. Staff reported that these arrangements for multi disciplinary working were effective and worked well.

We were told by a representative of a care home that the practice worked with mental health services in supporting people with dementia. That they worked with the community psychiatric nurses and the relevant psychiatrist.

The practice manager also attended regular meetings with practice managers in the area. This was to share information and to learn.

Information sharing

The practice used an electronic system to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. If a patient called 111 the detail of the call would be passed back to the practice by email, and followed up by a GP on the day. The GP would contact the patient to follow up on their call to 111 if they felt this was required.

Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Unless the patient was elderly or vulnerable, patients would be responsible for arranging their appointments at secondary services. If a patient was elderly or vulnerable this would be done for them by the practice staff.

Feedback we had from patients on the day of our inspection reflected that the system for referrals to secondary or specialist services worked well. For example one patient told us that their experience had been very good, they received their appointment in the required timeframe and the GP received the relevant results from the specialist service.

The practice also used a 'patient passport' system which had been introduced in the Clinical Commissioning Group area. The patient passport is a card, available to vulnerable patients, which can be scanned by other healthcare providers to give access to the patient's healthcare number. This enables other healthcare providers to access information about a patient such as their care plan. One care home representative we spoke with confirmed with us that people living in the care home were in the process of being issued with 'patient passports' by the practice.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. Staff were also familiar with Gillick competencies. (Gillick competencies are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.) We gave staff different scenarios, involving both adults and children, in which consent may be an issue of concern for a patient. We found the clinical staff we spoke with understood the key parts of the legislation and were able to describe, using the different scenarios, how they implemented it in their practice.

The nursing staff we spoke with were aware of the arrangements for gaining parental consent before issuing a vaccine. They were clear that childhood vaccinations would not be given if the child were brought in by a person other than the parent, for example by a grandparent or childminder. The nursing staff were aware of obtaining informed consent from patients. They told us they would describe the examination or treatment to the patient in advance and obtain consent before proceeding. We saw evidence of consent given by patients for cervical screening for example. We were informed by one of the GPs about how they made sure information was available to patients prior to giving consent to any minor surgery. A GP told us that they sought verbal consent prior to giving joint injections and recorded this on patients' notes.

Good

Are services effective?

(for example, treatment is effective)

A GP we spoke with was able to describe to us a situation about consent involving a patient with dementia, and the appropriate actions they took. Another GP described to us how they had supported a patient to make decisions about their end of life care arrangements.

Care home staff we spoke with confirmed that the GPs involved people living in the care home about decisions about their care, and were aware of when people may lack capacity, for example people with dementia. In these situations the GPs would liaise with the care home staff who knew the patients well. We were told that the GPs took action to ensure decisions were made in patients' best interest.

Information about advocacy services was not readily available in the patients' waiting room. Staff we spoke with were aware of advocacy services and some told us they would access this information using the practice's computer system.

Health promotion and prevention

The practice kept a register of patients with a learning disability, of which there were 12, and invited these patients to attend for an annual health check. At the time of our inspection all patients had been invited to attend for an annual health check although none had attended in the preceding 12 months. Two patients with a learning disability were due to attend for their annual health check shortly after our inspection. The practice had identified that this was an area in which they needed to approve and were considering action they might be able to take.

The practice identified the smoking status of their patients and one of the reception staff was the smoking cessation advisor and ran a weekly clinic. Appointments were for half an hour for the first appointment and 15 minutes for subsequent appointments. Patients were able to attend for a six week programme but they could attend for longer than this if they felt they needed to.

The practice's performance in the percentage of women who had attended for cervical screening was in line with the national average. Blood pressure monitoring of both patients with diabetes, and of patients with hypertension was projected, by the practice, to have improved in 2014/15 compared to 2013/14. Childhood immunisation rates were in line with the Clinical Commissioning Group average, and the practice offered a six week check for new babies. A medical questionnaire was available for new patients to complete as part of the registration process. This was also available online. New patient checks were also available with the healthcare assistant for new patients.

The practice offered a family planning clinic and free condoms to people under the age of 20. People did not need to be registered patients at the practice to access these services.

Health promotion information was available in the patients' waiting room. This included, for example, information about weight loss, eating well with diabetes, traveller health including travel to the Middle East, dental care and sexual health. There was also information about common viruses and how to treat them.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Our observation of patients attending the reception area of the practice was that they were treated with respect. There was a separate area from the waiting room for patients to speak with a receptionist to book appointments. There was also information available in the patient's waiting room about patient confidentiality and that patients could request to speak with staff in private. Our observations in the waiting room were that staff maintained patient confidentiality. In our discussion with one of the GPs they were able to describe the steps they took to maintain the confidentiality of patients who were travellers, for example in how they arranged follow up appointments.

Patients we spoke with were positive about how they were treated by staff. One patient we spoke with said that they felt the GPs were very good, as were the dispensary staff who they also described as obliging. Another patient we spoke with described the reception staff as friendly. Another patient we spoke with was positive about how the staff treated their children when they had an appointment at the practice. Other patients we spoke with were positive about their experiences at the practice.

Before our inspection we left comment cards for patients to complete to give their views on the practice. We received 32 completed comment cards. The majority of comments we received were positive about their treatment by staff. They described staff as friendly, respectful and helpful. One person commented on how the practice understood their preference for a gender specific GP which helped them feel more comfortable.

In the National GP Patient Survey 2015 83% of the patents reported that the last GP they saw or spoke to was good at treating them with care and concern and 85% of patients report that they felt the nurses were good at treating them with care and concern. 99% of patients reported that they had confidence and trust in the last nurse they saw or spoke to and 94% had confidence and trust in the last GP they saw or spoke to.

We reviewed those comments left by patients on the NHS Choices website over the preceding 12 months. Some comments were positive about their experience at the practice and others less so; referring negatively to the response they received from some staff. The practice responded to these comments on the website, and where appropriate requested patients contact the practice to discuss their concerns.

In the February 2015 Family and Friends Test all of the respondents, seven patients, said that they would recommend the practice. This compared with 65% of the respondents to the National GP Patient Survey 2015 who said that they would recommend the practice, which was lower than the CCG average.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. We noted in the staff training records that some staff had been trained in handling difficult conversations.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection confirmed to us that they felt involved in decisions about their care. They told us that they did not feel rushed and that the staff took time to explain things to them. One patient confirmed that they felt able to ask questions about their treatment and others confirmed to us that they were provided with treatment options.

Those patients who commented, using our comment cards, did not raise any concerns about their involvement in their care.

The National GP Patient Survey 2015 found that 82% of respondents said that the last GP they saw or spoke with was good at involving them in decisions about their care. This was above the Clinical Commissioning (CCG) average of 78%. In addition 85% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments which was also above the CCG average of 83%. 84% of respondents said the last nurse they saw or spoke with was good at explaining tests and treatments and 80% said the last nurse they saw or spoke with was good at involving them in decisions about their care.

Representatives of the care homes we spoke with told us that they found the GPs at the practice were courteous, and involved people in discussions about their care.

During our discussions with staff we were provided with examples where staff had assisted more vulnerable patients to make decisions about their care arrangements.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and on the practice's website told patients how to access a number of support groups and organisations. The practice website provided a search facility for services such as opticians and dentists. Information was also available about support groups and organisations for example to support those patients with asthma, those with mental health needs, and those who had had a stroke.

The practice had a carer identification protocol which included how to identify a carer, record this on the practice's records and so maintain a register of carers. The practice used this information to signpost carers to appropriate support services. Information for carers was available on the waiting room noticeboard.

We spoke with one patient who described positively their experience of the emotional support provided by the practice when they were a carer. They also said they were given advice on other services available to support them. We also saw a letter of thanks from a carer acknowledging the support and care shown at an extremely difficult time by one of the practice nurses. One of the clinical staff described to us a time when they had discussed end of life care arrangements for a patient who had limited capacity to understand.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with NHS England and its neighbouring practice to plan for the future needs of its population. The practice understood the needs of its patient population which included members of the travelling community. We found, for example, that consideration had been given to the more rural areas covered by the practice and changed the triage (GP screening) arrangements in place to ensure these were accessible to everybody. Those patients who attended the branch surgery in Felsted could visit the practice in person for triage rather than having to call the practice. The practice was also planning to increase the number of GPs employed as a response to the increasing population.

Staff had undertaken or were undertaking further training in response to patient need, specifically in the care of patients with diabetes and in mental health.

Care home representatives with whom we spoke told us that they found the practice was responsive to patients' needs. We were informed that the GPs supported people to remain at the care home and reduce any need for a hospital admission. This included patients who were near the end of their life; the GPs made arrangements with the district nurses to ensure medicines to aid pain relief were available including when the practice was closed.

The practice had a comments box in the patient waiting room area. We were told by representatives of the Patient Participation Group (PPG) that any suggestions made were discussed at the PPG meetings. We were given examples by the PPG representatives of changes made by the practice following discussions with them for example the telephone system. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.)

Tackling inequity and promoting equality

We were told that on occasions patients who could not speak English attended the practice, and that translation services were available. We were told that if a patient who could not speak English attended the practice they would be asked if they had anyone who could assist them, otherwise the practice would arrange a translation service. It was noted that a sign, in English, in the reception area advising of the translation service was no longer there. One of the GPs at the practice spoke a number of languages.

We were told that the Primary Care Trust had previously carried out an access audit at the practice to ensure compliance under the Disability Discrimination Act; which has since been replaced by the Equality Act. However the practice staff could not find details of the outcome of the audit or any action required and taken as a result.

We found that the premises were accessible to patients who had a physical disability. Consulting rooms were available on the ground floor and we noted that when patients were called for their appointment the doctor or nurse went to the waiting room to call the patient. A patient we spoke with confirmed to us that the premises were accessible for them when they had a pram or pushchair. They also confirmed that adequate baby changing facilities were available.

The practice had a loop system for patients who had a hearing impairment.

The practice would register patients who did not have an address, and those patients who were members of the travelling community were also registered at the practice. The practice was aware of their patients who did not remain in the practice's area. We were told that they were not deregistered from the practice until they had found a new GP in their new area and that they could still be seen at the practice. At the time of our inspection the practice was aware that some of their patients may have been 'sofa surfers' and did not have a permanent address.

Access to the service

Appointments with the GP were available at the main surgery from 8.30am to 11.30am, and from 3.30pm to 5.30pm Monday to Friday. In addition appointments were also available from 6.30pm to 7.30pm on Mondays and Thursdays. Branch surgery appointments with the GP were available from 8.30am to 11.30am Monday to Friday, and 4pm to 5.50pm Mondays, Tuesdays and Fridays.

Patients were asked to contact the practice between 11am to 4.30pm to make a non-urgent appointment.

Urgent same day appointments were available and this was confirmed by patients we spoke with.

Good

Are services responsive to people's needs?

(for example, to feedback?)

A telephone GP triage system was in place at the practice but this had been adapted at the Felsted branch surgery to take account of the limited mobile phone coverage in that area.

Three patients we spoke with said they found it was easy to get a non-urgent appointment with one stating that when they needed an appointment they could get one within a week or less. One patient commented positively on the arrangements to get an emergency appointment. One patient we spoke with said that they found getting an appointment could be difficult and they may have to wait a week or more. Another patient commented positively on the access to ante natal care.

Some patients, in their comment cards, reflected that it could be difficult to get a non-urgent appointment with a wait of about two weeks. In addition some patients who completed our comment cards reported that they were not always able to see the same GP. Two patients noted the impact this had in that they felt they needed to explain their health needs each time. One patient commented that the availability of evening appointments was good for those who worked. There were notices in the patient areas advising patients of the facility for evening appointments.

The National GP Patient Survey 2015 noted that 61% of respondents described their experience of making an appointment as good. This was below the Clinical Commissioning Group average of 68%. The practice's patient survey in February 2015 found that only 11% of patients were aware that they could make appointments on line. The practice had since taken steps to improve patient awareness of the online booking facility.

The practice website provided contact details of the 111 service which was available outside of the practice opening times.

Listening and learning from concerns and complaints

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

Information about how to complain was available on the practice website as was information about the Patient Advise and Liaison Service. Information about how to complain was also displayed in the practice for patients. Patients we spoke with were not aware of the complaints procedure but those who we asked said that if they had any concerns they would feel comfortable raising these.

The practice had received 20 complaints in the 12 months preceding our inspection. We reviewed three complaints recently received by the practice. We found that these were investigated and appropriately responded to in a timely manner. We also found that complaints were discussed in partner meetings. This was reflected in the minutes of the February and March 2015 partner meetings which we reviewed. We were informed, by one of the GP partners, that the learning from any complaints was discussed with any staff directly involved and also at other meetings held within the practice, for example nurse meetings, and dispensary meetings.

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 patient charter, which had been developed with staff and also with the Patient Participation Group (PPG), and was on display in the patient waiting room. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The patient charter set out the aim of the practice to provide the best quality care available. It also detailed the practice's vision that the quality of the service would be such that they would be happy for their own family and friends to use the service.

Staff we asked described the practice ethos as one where they aimed to treat patients with respect, and equal treatment of all patients; that the practice was patient focussed.

It was evident that the practice had considered the future needs of its population and was taking steps to address this. For example by increasing the number of GPs at the practice, and ensuring the premises from which the practice was run could meet this anticipated increase in demand for its services.

Governance arrangements

We reviewed five policies and procedures and found that all were up to date and detailed future review dates. The policies and procedures were available on the practice's computer system.

Different staff had lead roles with in the practice, and every GP partner had a lead role. Examples included a lead member of staff for safeguarding, another for staffing matters, another for safeguarding, and one for performance, amongst others. Staff who were registered patients at the practice were not seen by one of the partner GPs if they needed to attend for an appointment. This was to reduce any potential conflict of interest between the staff member and the practice partners.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.) We found that the QOF data was used to help drive improvements in the services provided. Staff told us that QOF data, which was brought together by the IT manager at the practice, was regularly discussed at the general practice meeting. The minutes we saw reflected that all areas of performance were discussed and included forward planning and any outstanding areas of work to be addressed.

Although there was evidence that the practice had completed clinical audits to improve practice, some audits we reviewed had not yet been completed.

The practice did not have a risk log but there were plans to complete a written risk log.

Leadership, openness and transparency

A practice general meeting was held monthly and included clinicians and administrative staff. The practice also held monthly staff meetings which included all administrative and nursing staff and a representative of the dispensary staff; on occasions a GP also attended. Staff reflected to us that the meetings provided a forum for a two way conversation. We were told that the arrangements for staff holidays had recently been reviewed and a compromise between the staff and partners had been achieved. As well as a range of formal meetings we also noted that the staff in the practice met periodically for social events.

Staff told us that one of the GPs was involved in the appraisals of the administrative staff which they felt helped staff feel valued. The PPG representatives we spoke with also reported that they felt valued by the practice, and that they were encouraged to be open about their views. The practice had introduced a staff suggestion box at both the main and branch surgeries. Suggestions to improve the practice could be made confidentially using the suggestion box thereby increasing staff involvement and innovation. One member of staff we spoke with told us that all staff were actively encouraged to raise suggestions for improvement.

The nursing staff we spoke with also reflected that they felt the senior staff were approachable. Although there was a designated lead GP for the nursing team, we were told by one of the nurses with whom we spoke that they could approach any of the GP partners.

Seeking and acting on feedback from patients, 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 had both a PPG that met together, as well as a virtual PPG of patients who were unable to attend regular meetings but who were able to contribute 'virtually'. The PPG representatives we spoke with told us that they received feedback on patient and public suggestions submitted using the suggestion box in the waiting areas of the practice. They told us that they felt that feedback they gave was taken account of by the practice. We were told that the way in which patients were greeted when they arrived at the practice for an appointment had changed. They believed this was a result of both PPG feedback and complaints. We were also told that the suggestion, by the PPG, of a television screen in the patient waiting room was now being considered by the practice.

We saw that the practice considered areas for improvement arising out of complaints; for example individual staff development as well as the processes and systems in place.

The practice, supported by the PPG, carried out an annual patient survey. The most recent patient survey was carried out in February 2015, following consultation with the PPG as to the questions to be included. Action taken by the practice in response to this most recent survey included improving patient awareness of the online appointment booking facility, and reviewing the system in place for managing repeat prescriptions. The practice also responded to the triage system in place in the branch surgery where mobile phone reception was not always reliable. The patient survey also found that patients would benefit from one longer appointment for disease management. The practice agreed to implement this including ensuring any routine screening such as blood tests were also carried out at the same time.

The practice had recently introduced a service improvement award for staff which was a system for recognising staff contribution to suggestions for improvement in the practice. In March 2015 this had included the suggestion of a review of the practice information leaflet provided to patients.

A staff whistleblowing policy was in place in the practice.

Management lead through learning and improvement

We found that staff had regular appraisals which included a development plan. There was evidence that staff were supported to attend training to improve the services provided to patients. We found that staff had been supported to develop in the practice for example the health care assistant had previously been employed as a member of the administrative team. One of the administrative team was the smoking cessation advisor. Staff we spoke with confirmed that the practice was very pro-active in respect of training. This included both online learning as well as other courses dependent on need.

One of the GP partners was clinical lead for older people at the Clinical Commissioning Group. The practice was a research practice, and had contributed to clinical studies.

The practice was a training practice. The trainee we spoke with was positive about their experience at the practice.