

Whitley House

Quality Report

Crompton building
Writtle road
Chelmsford
Tel: 01245 347539
Website: www.whitleyhouse.co.uk.

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Whitley House Surgery on 8 March 2016. Overall the practice is rated as good. The practice is rated as outstanding for the care of older people.

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

- Patients were protected from abuse and avoidable harm as staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Risks to patients were assessed and managed. Information about safety was monitored, appropriately reviewed and addressed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. There were multi-disciplinary team discussions to ensure patients' care and treatment was coordinated and data showed that the expected outcomes were comparable to other surgeries in the area.
- Patients said they were treated with compassion and dignity and they were involved in their care and decisions about their treatment. Information about services and how to complain was available and easy to understand.
- Patients said they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The premises were purpose built and maintained to an acceptable standard throughout the clinical areas. Access for disabled people was in place including parking for the disabled and washroom facilities.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- There was a leadership structure. Staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. Staff received satisfactory supervision and appraisal and were supported to undertake their

Summary of findings

continual professional development. Clinical staff and doctors were supported to participate in training and development which would enable them to deliver good effective quality care.

We saw one area of outstanding practice:

- We were told that Whitley House was the lead GP practice in Chelmsford for the 100 day Frailty Challenge set up as an initiative by the CCG involving six other GP practices as a pilot to improve care for frail patients. In the first three months of the initiative the reduction in avoidable admissions for that cohort of patients, was 17% and these practices have shown a 4% reduction from 14/15 to 15/16. This compares with a 9% increase for all other practice, so a very significant difference. This way of working, with enhanced multi disciplinary teams and the involvement of patients completing a narrative about themselves and their needs, has resulted in the initiative being extended into long term care and is including joint work between primary and secondary care. The CCG have also recognised that this initiative has improved relationships between GP practices and health and social care partners.

The areas where the provider should make improvement are:

- Ensure that the system for checking the medicines carried by GPs when away from the practice is more robustly monitored. Ensure that there is an effective system for documenting the control of stock in relation to vaccines in use at the practice and their expiry dates. Ensure records of these checks are recorded.
- Ensure that all staff are aware of the issues affecting the practice including the objectives, performance and the learning from significant events and safety incidents.
- Ensure policies are up to date and reflect current practice.
- Improve the identification of patients who are carers.

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



- Patients were protected from abuse and avoidable harm as staff we spoke with were confident to report serious incidents, whistle blow or challenge if they suspected poor practice. There was an open culture to encourage a focus on patient safety and risk management practices. Arrangements were in place to implement good practice although it was not always clear how this information was cascaded to all relevant staff to heighten awareness and ensure lessons were learnt.
- Risks to patients were assessed and well managed. Medicines were managed safely and securely stored; checking systems for GP home bags and vaccine storage were not documented to evidence ongoing safe practice. Infection control procedures were being followed. Health and safety risk assessments had been completed and staff were receiving chaperone training and followed procedures.
- The surgery had provided safe staffing levels and skill mix and had encouraged teamwork to support a safe environment. Ongoing recruitment was being actioned where needed.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There were arrangements in place to deal with foreseeable emergencies and accessible emergency equipment and medication at the surgery.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Processes were in place for implementing and monitoring the use of best practice guidelines and the practice demonstrated positive outcomes for patients through the care and treatment provided.
- Data from the Quality and Outcomes Framework showed patient outcomes were satisfactory for the locality and compared to the national average.
- The surgery routinely collected outcomes information and participated in clinical audits, national benchmarking and peer review to encourage service developments and quality improvements.

Summary of findings

- All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. Staff received continual professional development, supervision and annual appraisals and staff told us they felt valued and supported by the organisation. Staff training needs and development was being met.
- There were multi-disciplinary team meetings to ensure patients' care and treatment was coordinated and the expected outcomes were achieved.

Are services caring?

The practice is rated as good for providing caring services.

- Patients and family members spoken with were positive about the services provided. We reviewed written CQC cards, which ranged from good to excellent for support and respect from staff. Patients said they were treated with compassion and dignity and they were involved in their care.
- We found that care was patient centred. The provider encouraged staff to develop services to provide patients with support where needed. Data from the national GP patient survey showed patients rated the practice similar to others for most aspects of care.
- Staff in all roles treated patients with dignity and patients felt well-cared for as a result. Patients we spoke with and those close to them were encouraged to be involved in their care, were listened to and were involved in decision making at all levels.
- Information for patients about the services available was easy to understand and accessible in the waiting areas, including support groups in the community.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Appointments were available with a named GP when available and there was continuity of care, with urgent appointments available the same day. Extended early surgery hours were available for patients at the practice on Tuesday, Thursday and Friday.

Good



Summary of findings

- Information about how to complain was available and easy to understand and evidence showed the practice responded to issues raised. Learning from complaints was shared with staff.
- Staff worked with other healthcare professionals and external agencies to ensure that responsive care was delivered.

Are services well-led?

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

- The practice had a focus on continuous learning and improvement at all levels.
- There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. Staff told us they received feedback when they were performing well and would be confident to challenge poor performance to improve quality of care. Staff were consulted about all relevant issues affecting the practice.
- Staff understood the staffing structures and were aware of their own roles and responsibilities. Succession planning was in place and continuous professional development encouraged.
- Arrangements were in place to monitor and improve quality and identify risk through a programme of continuous clinical and internal audit.
- The current recording of governance arrangements did not always support the systems in place to ensure shared learning and quality improvements in patient care at all times.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- The practice worked in partnership with their patient participation group (PPG) and with the local community in planning how services were provided to ensure that they met patients' needs.

Good



Summary of findings

The six population groups and what we found

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

Older people

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

- Whitley House was the lead GP practice in Chelmsford for the 100 day Frailty Challenge set up as an initiative by the CCG involving six other GP practices as a pilot to improve care for frail patients. In the first three months of the initiative the reduction in avoidable admissions for that cohort of patients, was 17% and these practices have shown a 4% reduction from 14/15 to 15/16. This compares with a 9% increase for all other practice, so a very significant difference. This way of working, with enhanced multi disciplinary teams and the involvement of patients completing a narrative about themselves and their needs, has resulted in the initiative being extended into long term care and is including joint work between primary and secondary care. The CCG have also recognised that this initiative has improved relationships between GP practices and health and social care partners.
- The practice offered responsive, proactive, personalised care to meet the needs of the older people in its population. Nationally reported data showed that outcomes for patients were comparable for conditions commonly found in older people.
- The surgery offered senior health checks for all those over 75 years and they all had a named GP. The practice offered home visits and urgent appointments for those with enhanced needs.
- The GPs reviewed all registered care home residents six monthly and liaised closely with care staff, relatives and carers regarding advanced care planning to ensure patient's wishes were acted on.
- Telephone appointments and home visits were available for those who were unable to get to the surgery. A carer's register highlighted those who cared for a loved one and who may need support and advice.
- GPs worked with local multidisciplinary teams to reduce the number of unplanned hospital admissions for patients at risk, including those with dementia and those receiving end of life palliative care.
- The surgery had links with a community agent who provides social and economic advice and support to older people in their homes.

Outstanding



Summary of findings

People with long term conditions

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

- Patients with long term conditions had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Doctors and nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Chronic disease reviews were offered in the surgery or at home if the patient is housebound. Diabetes Protocols were followed with support from the Diabetes lead doctor and COPD/Asthma annual reviews and follow up appointments were actioned with a trained Asthma Nurse.
- A recall system was in place to ensure continuity of care for all disease management of long term conditions, together with medication reviews and follow up checks as and when required or requested. There were anti coagulation blood testing and dosing clinics provided by the practice nurse for people with blood clotting disorders.

Good



Families, children and young people

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

- The surgery offered appointments at various times during the day starting at 7am. Sit and wait surgeries for the later morning had been introduced and these were extended if demand required it. The duty doctor system ensured same day access for any urgent phone enquiries or patients needing same day assessment.
- The GPs were involved in both antenatal and post-natal care to keep continuity of care for families and the ongoing relationship with the new child and mother. They liaised with the midwife who attended the surgery for weekly clinics.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Children on the at risk register had a named GP and the practice had an open door policy for children if a parent requests a same day appointment.

Good



Summary of findings

- Childhood immunisation programme was offered with follow up to patient's parents/carers if appointment is not attended. Immunisation rates were comparable with the CCG for all standard childhood immunisations.

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. The practice offered early morning appointments which were pre bookable and commenced at 7am, three days per week.

There were also telephone triage appointments and double appointments available where necessary.

- The practice was proactive in offering online services including the booking of appointments and repeat prescriptions were able to be ordered on line as well as a full range of health promotion and screening that reflected the needs for this age group, such as Health Trainers and Walking for Health support programmes.
- Patients were aware of SMS text messaging services and were complimentary about the flexible consultative approach of the practice.

Good



People whose circumstances may make them vulnerable

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

- The practice worked with multi-disciplinary teams in the case management of vulnerable people to ensure that patients whose circumstances made them vulnerable were supported holistically. The practice offered annual health checks for patients with learning disabilities. There was a specifically modified recall system and letters to encourage attendance with the practice nurse who had links with the local learning disability lead nurse and team to ensure best practice and utilising local resources.
- The practice carried out home visits to undertake health reviews as needed and offered longer appointments for

Good



Summary of findings

vulnerable patients. They saw all those registered at the local homeless centre and temporary registration was encouraged along with NHS screening and health checks to improve health outcome for this vulnerable group.

- The practice informed 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.

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 practice was working towards becoming a "Dementia friendly practice" following an initial meeting in January 2016 with the Alzheimer's Society. There was a forum to discuss best care for dementia patients and their carers. All carers were offered the opportunity to be coded on their notes as "carers" so opportunistic health screening could take place for them..
- All mental health and dementia patients were offered individual care plans and any appropriate advanced care planning (IAM forms). All were invited to annual physical health reviews and the surgery followed up and called any non-attenders to encourage compliance. 71% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to other practices.
- The practice offered annual checks, extended appointments and regular telephone appointments for patients experiencing poor mental health. Advice was provided about how to access various support groups and voluntary organisations. Systems were in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Good



Summary of findings

What people who use the service say

During the inspection we met with a representative of the patient participation group (PPG) and spoke with nine other patients in the surgery. There were positive views from all of the patients and those close to them about the care provided. All patients said they were happy with the care they received and thought staff were caring, approachable and treated them with dignity and respect.

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. 255 survey forms were distributed and 112 were returned. This represented a 43.9% return rate.

- 88% said the last GP they saw or spoke to was at giving them enough time compared to a CCG average of 85% and a national average of 86%.
- 85% said the last GP they saw or spoke to was at treating them with care and concern compared to a CCG average of 83% and a national average 85 %.

- 93% said the last appointment they got was convenient compared to a CCG average of 92% and a national average 91%.

There was one area where the practice was not performing in line with local and national averages:

- 79% of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern. (01/07/2014 to 31/03/2015) compared to the national average of 90%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 11 comment cards which were all positive about the standard of care received. Views ranged from good to excellent for care and attention received from the doctors and practice nurses.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that the system for checking the medicines carried by GPs when away from the practice is more robustly monitored. Ensure that there is an effective system for documenting the control of stock in relation to vaccines in use at the practice and their expiry dates. Ensure records of these checks are recorded.
- Ensure that all staff are aware of the issues affecting the practice including the objectives, performance and the learning from significant events and safety incidents.
- Ensure policies are up to date and reflect current practice.
- Improve the identification of patients who are carers.

Outstanding practice

- We were told that Whitley House was the lead GP practice in Chelmsford for the 100 day Frailty Challenge set up as an initiative by the CCG involving six other GP practices as a pilot to improve care for frail patients. In the first three months of the initiative the reduction in avoidable admissions for that cohort of patients, was 17% and these practices have shown a 4% reduction from 14/15 to 15/16. This compares with a 9% increase for all other practice, so a very significant difference. This way of working, with enhanced multi disciplinary teams and the involvement of patients completing a narrative about themselves and their needs, has resulted in the initiative being extended into long term care and is including joint work between primary and secondary care. The CCG have also recognised that this initiative has improved relationships between GP practices and health and social care partners.

Whitley House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice manager specialist adviser and an expert by experience.

Background to Whitley House

Whitley House surgery provides primary care services to a population of approximately 12300 patients in the Chelmsford area. The practice holds a General Medical Services (GMS) contract. The premises is purpose built and there is designated parking for the disabled on site.

The practice has three female and two male doctors, one nurse practitioner, three practice nurses and two health care assistants. There is also a practice manager, administration and reception staff.

The practice population is slightly higher than the national average for those of working age over thirty. Economic deprivation levels affecting children, older people and unemployment are lower than the practice average across England. Life expectancy for men and women are similar to the national averages. The practice patient list is similar to the national average for long standing health conditions and lower disability allowance claimants. The number of care home patients is comparable to national averages.

The surgery is open every day of the working week from 8am until 6.30p.m. There are early morning starts from 7am Tuesdays, Thursdays and Fridays to support commuters and working families. Telephone access is available from 8am. They offer both face-to-face and telephone appointments. Patients also have on line options to book appointments.

Emergency appointments are available throughout the day. The practice has opted out of providing GP out of hour's services. Unscheduled out-of-hours care is provided by the NHS 111 service and patients who contact the surgery outside of opening hours are provided with information on how to contact the service. This information is also available on their own and the NHS choices website.

This practice has been accredited as a GP Training Practice and will have attached to it one or more qualified doctors training to specialise in General Practice.

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 we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 March 2016. During our visit we:

Detailed findings

- Viewed information provided by the practice, which included feedback from people using the service about their experiences.
- Spoke with a range of staff (receptionists, practice nurses, practice manager, administrators and doctors) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

- Is it safe?
- Is it effective?
- Is it caring?

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

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

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

Are services safe?

Our findings

Safe track record and learning

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

- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings. Information about safety was monitored, reviewed and addressed although not always clearly documented. Staff knew how to report serious events, whistle blow or challenge if they suspected poor practice which could harm a person. They would inform the practice manager of any incidents and there was a recording form available for noting incidents on the shared drive. We saw examples such as an incorrect swab result and another around incorrect mobile phone contact numbers alerts. Whilst responses and actions were noted on the log and most staff were clear on actions taken the minutes we looked at did not always demonstrate how this information was cascaded to all relevant staff to heighten awareness and ensure lessons were learnt.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. An example given was difficulties experienced getting appointments, a meeting was held with explanations around the appointment system and action with reception staff regarding improved communication practices.

Overview of safety systems and processes

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

- Safeguarding policies and procedures were in place which were understood and implemented by staff. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs had been trained to an appropriate level to manage safeguarding concerns All safeguarding report requests were actioned and processed by the duty doctor. All

were flagged and coded and we saw through minutes that the lead GP met regularly with the health visitor, school nurse, midwife, GP nurse and admin team to discuss individual cases.

- Staff who acted as chaperones were checked for suitability and trained for the role.
- There was an infection control policy in place and clinical staff had received training. Infection control audits were undertaken and practices reviewed. Sharps bins and disposable curtains were dated and areas were visibly clean. There were protocols in place for needle stick injuries.
- Staff we spoke with were aware of medicine management policies and monitoring systems were in place to pick up medicine errors. The arrangements for managing medicines, including vaccinations, in the practice kept patients safe (including obtaining,

Handling, storing and security) although they were not always recorded. We were told that vaccine stock and expiry dates were checked regularly however they were not recorded as actioned. GPs carried emergency medicines when visiting patients away from the practice. We saw the checking system was not fully embedded as when we checked those bags we found that some medicines expected to be carried were not present but all were in date. The practice told us they would review their checking systems and make improvements to ensure omissions were picked up at all times.

- Patient safety alerts were reviewed by the lead GP who made appropriate clinical decisions. The information was then shared with other staff if relevant to their role. This ensured patients received effective consultations and treatment.
- Staff followed robust recruitment practices and were actively involved in the interviewing process. They told us that the induction was helpful to new starters. We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up

Are services safe?

women who were referred as a result of abnormal results. The practices uptake for the cervical screening programme was 81% which is comparable to the national average of 81%.

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. We saw that equipment was routinely checked for electrical safety and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as infection control Health & Safety and Legionella water safety. The practice had up to date fire risk assessments and fire training was provided to all staff.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were episodes of staff shortages at times and recruitment was ongoing to

address this. Staff told us they were confident that managers ensured, where able, that the right staffing levels and skill-mix were sustained to support safe, effective patient care and levels of staff wellbeing.

Arrangements to deal with emergencies and major incidents

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.

- There were procedures for dealing with medical emergencies and major incidents. All clinical staff received annual basic life support training and those we spoke with were able to describe how they would respond in the event of a medical emergency. The practice had procedures in place to assist staff to deal with a range of medical emergencies such as cardiac arrest, or anaphylaxis (severe allergic reaction) Emergency medicines and kit were available.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with staff on the day of our inspection and were satisfied that care and treatment was being delivered in line with best practice and legislation. They were aware of the guidance provided by the National Institute for Health and Care Excellence (NICE) and how to access the guidelines.

- We saw a recent initiative to incorporate the new NICE guidelines on children with a fever which involved developing a protocol that was built directly into their computerised patient record system. This guided clinicians and automatically recorded and coded the information in the patient's notes. The GP partners at the were currently in the process of testing it. This involved a pre-implementation audit, before doing a local roll out and completing the audit cycle.

We reviewed eight audits provided to us by the practice. Four were full two cycle audits and one of these was progressing to a third cycle. The outcome of the audits were generally clear identifying where the practice should make improvements. It was not always clear how the change in practice was to be cascaded to other clinicians. The number of audits and especially the number achieving two cycles indicate that this was a practice that reflected on its standard of care, seeks to measure aspects of care and then draw conclusions that inform a change in practice. One example was a recent review of a Shared Care Drug Protocol in January 2016 which was re-audited in February 2016 to identify whether patients on the shared care drug protocol for medicine were having their recommended blood tests. Blood tests were found to be below the level required. Action had been taken to improve and the second audit showed improved results. The protocol was revised, staff informed and a third audit cycle proposed.

Management, monitoring and improving outcomes for people

GPs, staff and patients we spoke with told us that the practice was proactive in promoting patients' health and disease prevention to improve outcomes for people. This included offering set appointments with a health trainer for lifestyle advice, stop smoking clinics, family planning support and flu clinics.

We looked at monitoring systems and spoke with lead staff about the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice) The most recent published results were 96% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets and showed low exception rates. Data from the year 2014 to 2015 showed;

- Performance for diabetes related indicators was similar to the CCG and national average. Such as: 86% of patients with diabetes, on the register, had influenza immunisation in the preceding 1 August to 31 March (01/04/2014 to 31/03/2015) compared to a national average of 94%
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2014 to 31/03/2015) was comparable to other practices at 80% and to the national average of 83%.
- The percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the preceding 12 months (01/04/2014 to 31/03/2015) was comparable to other practices at 94% and to the national average of 94%.

We were told that Whitley House was the lead GP practice in Chelmsford for the 100 day Frailty Challenge, a CCG initiative involving a pilot with 7 practices to improve care for frail patients. In the first three months of the initiative the reduction in avoidable admissions for that cohort of patients, was 17% and the 7 practices have shown a 4% reduction from 14/15 to 15/16. This compares with a 9% increase for all other practice, so a very significant difference. This way of working, with enhanced multi disciplinary teams and the involvement of patients completing a narrative about themselves and their needs, has resulted in the initiative being extended into long term care and is including joint work between primary and secondary care. The CCG have also recognised that this initiative has improved relationships between GP practices and health and social care partners.

Performance for Diabetic related indicators was comparable to the CCG and national average, apart from one area which we followed up:

Are services effective?

(for example, treatment is effective)

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 60% compared to the national average of 78%.

We were told that a new lead nurse would start working at the practice on 11th April 2016 to support diabetic care moving forward and improve the practice performance in relation to diabetic health indicators.

The surgery had identified all of their patients with sub-optimal blood pressure readings and they were being reviewed as a matter of priority. They had recently employed a community pharmacist to help review diabetic patients and they were already running weekly clinics to develop the service.

Effective staffing

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

- Staff told us about the procedure for recruitment and induction practices. A recent employee told us about the induction programme for newly appointed staff. It covered such topics as safeguarding, fire safety, health and safety and confidentiality. Shadowing was also provided to support new starters and encourage integration.
- The surgery was a training practice for GPs and the recent . Feedback from trainee GPs we spoke with at the practice was positive about the training and support they received.
- Staff demonstrated how they received role-specific training and updating. For example, the practice nurses qualifications ,work experience and ongoing training showed competencies for reviewing patients with long-term conditions, administering vaccinations and taking samples for cervical screening. Staff gave examples such as Health Care Assistant five day courses, travel vaccine updates and asthma distance learning diplomas agreed during appraisals to support their continual professional development.
- We saw training logs which showed that clinical and non-clinical staff had access to training to meet their learning needs and to cover the scope of their work.

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.

- Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw through the Enhanced Frailty meeting minutes and discussions with seven staff that care and treatment was discussed and reviewed to ensure that appropriate and relevant information was available to all the agencies involved in patients care and treatment.
- Referrals to the rapid assessment unit and direct referrals for elderly care helped support the hospital admission avoidance policy.

Consent to care and treatment

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

- Patients' consent to care and treatment was always sought in line with legislation and guidance including the Mental Capacity Act 2005. The practice had policies and procedures around obtaining patients consent to treatment. Staff we spoke with could demonstrate that they understood and followed these procedures. GPs and the practice nurse's we spoke with told us when providing care and treatment for children, young people or where a patient's mental capacity to consent to care or treatment was unclear, assessments of capacity to consent were carried out in line with relevant guidance.
- We saw "consent to share" on the IAM forms and verbal consents for immunisations were recorded via the online template.

Supporting patients to live healthier lives

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

- The GPs reviewed all registered care home residents six monthly and liaised closely with care staff, relatives and carers regarding advanced care planning to ensure patient's wishes were acted on. We spoke to one residential home manager who was complimentary

Are services effective? (for example, treatment is effective)

regarding this service, highlighting ongoing continuity of care and health promotion services as very good. This meant these patients had been able to gain access to management of their long term conditions such as diabetes, pulmonary disease and dementia care.

- The practice had a health trainer and a smoking cessation advisor attached to the surgery to support patients with lifestyle choices, health promotion and social and economic support systems. We were given examples of correspondence and liaison from GPs with social workers, occupational therapists for home adaptations and mental health teams for assessments to support patients to live healthier lives.
- Patients had access to appropriate health assessments and checks. These included health questionnaires for

new patients and NHS health checks for people aged 40 to 74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Flu vaccination rates for the over 65s were 69%. These were also comparable to national averages of 73%.

- The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 81%. Breast and bowel screening programmes were comparable to national averages.
- Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 91% to 96% and five year olds from 94% to 98%.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that staff were polite and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Patients told us that staff addressed them in a polite manner and reception staff were careful about what could be overheard near the waiting room.

We met with one representative of the patient participation group and spoke with nine other patients in the surgery. There were positive views from all the patients and those close to them about the care provided, which they all noted was patient centred. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We saw thankyou cards outlining the professional caring approach of doctors and staff and the last Family and Friends Test scored 100% for patients would recommend the surgery.

We saw that members of staff were courteous and very helpful to patients and treated them with dignity and respect. We saw an example of compassionate care to a distressed patient in the waiting room and community nurses and patients reinforced this stating that the doctors and staff go above and beyond the call of duty at times.

All of the 11 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good and at times excellent service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey published in July 2015 showed patients felt they were treated with compassion, dignity and respect. The practice was similar to other practices for its satisfaction scores and this was confirmed by patients we spoke with. For example:

- 97% had and trust in the last GP they saw or spoke to compare to the CCG average of 94% and national average of 95%.
- 85% said the last nurse they saw or spoke to was at giving them enough time compared to the CCG average of 91% and national average of 91%.

Care planning and involvement in decisions about care and treatment

We saw arrangements were in place which showed that the provider supported patients in being involved in their care, even when they lacked the capacity or needed advocates to speak on their behalf. This was also confirmed by a care home manager and the community nurses we spoke with. Patients told us they were able to ask questions if they were unsure about what was happening to them and understood about their care. They were kept informed and treated with respect and dignity by the staff providing the care. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 85% said the last GP they saw or spoke to was at listening to them compared to the local average of 87% and the national average of 88%.
- 84% said the last GP they saw or spoke to was at involving them in decisions about their care compared to the local average of 79% and the national average of 81%.

There was a large variation which we followed up:

- 79% of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern, compared to the national average of 90%.

All the patients we interviewed and comment cards we received did not highlight this as an issue. We were told by the practice that they thought that vacancies in the nursing team may have impacted on the satisfaction rates. We were informed that recruitment and training was ongoing to develop the service provision.

Staff told us that translation services were available for patients who did not have English as a first language. There was clear translation information on the website.

Patient and carer support to cope emotionally with care and treatment

Are services caring?

Whitley House used prognostic indicators to ensure they identified patients who might be in their last year of life. The GPs encourage the use of the IAM form as part of advanced care planning especially with dementia patients whilst they still have capacity. Examples were given of individual care packages where the doctors worked closely with the community nurse specialists and integrated district nurse team to ensure patient and carer support to cope emotionally with care and treatment. Patients were flagged on the electronic record if they were palliative. This alerted the whole team that this group of patients may have specific needs. Complex need patients had a named GP to ensure continuity of care. Those bereaved have had contact from one of the team and a sympathy card was also sent.

- The practice's computer system alerted GPs if a patient was also a carer. The practice register of all people who are carers was 0.8% of the practice list size which is significantly lower than the national average of 2%, therefore the practice should consider how they proactively identify carers. We checked and noted that the surgery had information in the waiting room and a website for further information on carers such as the Action for family carers support network. They hand out forms to those who wish to register as a known carer. There were double appointments for carers who felt they needed extra support and a clear carer's identification protocol for staff reference. We spoke to one carer who told us that the surgery were supportive.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. One GP is on the board of the CCG and worked in partnership with the patient participation group to represent the practice and patients in developing responsive services.

- The practice was also working towards becoming a "Dementia friendly practice" following an initial meeting in January 2016 with the Alzheimer's Society. All mental health and dementia patients were offered individual care plans and any appropriate advanced care planning (Information About Me forms). All were invited to annual physical health reviews to ensure good access to the services. The surgery followed up and called any non-attenders to encourage compliance.
- One of the practice nurses carried out extensive health checks annually for all patients with a learning disability and recently developed easy read leaflets and health care questionnaires to help patients highlight their individual needs to ensure a responsive service. The nurse also had linked up with the local learning disability lead nurse and team to ensure best practice and utilising local resources. There was a specifically modified recall system and letters to encourage attendance. There were 31 patients on the register and all of them had received a health review.

Access to the service

- Patients and the patient participation group (PPG) told us the practice responded well to issues raised by them. Such as the introduction of the on line appointment system and "sit and wait" appointments service to improve access to appointments and same day visits. The sit and wait clinic had resulted in more patients being seen 'on the day' when needed which was evidenced by less GP calls being required.

- The surgery implemented a new phone system as part of a previous year's PPG action plan and continued to review call data daily, call volume, call wait times and peak call times. These were discussed at PPG meetings and ideas and processes regularly changed to improve performance and access to services. This included information to patients through the PPG newsletter, posters and phone campaigns. The PPG meeting minutes that we viewed reflected that a considerable reduction had been achieved in the rates of patients that did not attend for an appointment but we did not have specific data to refer to on the day of the inspection.
- The PPG and surgery had also identified hard to reach groups and tried and gained feedback from these groups via methods specific to the needs of the group, often via individual phone calls to patients. We were told that these calls had provided invaluable feedback and it was reported that patients in these groups had expressed gratitude that their opinions had been sought and considered.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 93% said the last appointment they got was
- < > said they didn't normally have to wait too long to be seen compared with a local average of 57% and a national average of 57%. We looked at the complaints audit for 2014/2015 and there had been 31 complaints recorded. Our findings showed that management and monitoring systems were in place to highlight any trends such as staff communication and attitude, surgery management and clinical practice. We found lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. Examples included improved communication with patients about the prescription process and the processing of medical reports.

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 lead GP discussed an ongoing strategy to deliver high quality care and promote good outcomes for patients, including becoming a "Dementia friendly practice" and developing the frailty service.

- We saw a mission statement in the waiting area and staff and patients were aware of it. Staff we spoke with was clear on the day to day operational management of the surgery and the challenges such as recruitment and increasing numbers of patients due to the closure of a neighbouring surgery. They were aware of service developments. Staff had an understanding of the priorities for the coming year in relation to services, patient safety and cost effectiveness, but there was no formalised approach to this.

Governance arrangements

There was a governance framework which supported the delivery of good quality care. This included arrangements to monitor and improve quality and identify risk through a programme of continuous clinical and internal audit.

- There were policies for identifying and managing risks, issues and implementing mitigating actions. Governance systems were in place but documenting and monitoring check lists required development such as for the GP home visit bags and vaccine stock monitoring to show ongoing safe practice. One policy regarding blood results management did not reflect current practice; we raised this at inspection and were assured that this would be actioned and the policy changed accordingly.
- There was an emphasis on learning from significant events, complaints and clinical audits and staff told us these were discussed at weekly partner meetings and shared with clinical staff through the electronic notification systems and clinical meetings. However, the process was not recorded robustly to demonstrate how this information was cascaded consistently across the teams to ensure shared learning as some meeting minutes lacked detail.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality

care. They prioritised safe, quality and compassionate care. The partners were visible in the practice and staff and external stakeholders told us they were approachable and always took the time to listen to members of staff.

- There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. Staff told us they received feedback when they were performing well and felt confident to challenge poor performance to improve quality of care.
- Staff had clearly defined roles and responsibilities and they told us they had a sufficient skill mix of staff across all the roles to deliver the care needs of the patient population. There had been a recent management gap of a practice manager and lead nurse which we were told had impacted on some of the data and quality monitoring practices. The practice were actively recruiting for new staff at the time of the inspection. All of the staff we spoke with talked about their commitment to patients and providing a quality service. Patients we spoke with said the staff were professional and helpful. Clinical staff told us they were well supported and that team working was a key strength of the practice.
- The provider was aware of and complied with the requirements of the Duty of Candour. Staff told us there was an open culture where they could raise concerns and these would be acted on. The practice had processes in place for knowing about notifiable safety incidents and we were told this information was shared with staff to ensure appropriate action was taken although this was not always documented.

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

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

- The practice had an active Patient Participation Group (PPG) and had a membership of 10 active members and approximately 100 virtual patients. The PPG worked closely with the local community in planning how services were provided to ensure that they met patients' needs. For example:
- The PPG helped to re-write the practice leaflet. The leaflet now contained a dedicated page about the PPG

Are services well-led?

Good 

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

and how to join it. The PPG distributed their newsletter to local care and residential homes, warden controlled homes, retirement homes, which were within the practice's boundary area. The practice installed sophisticated text messaging software as part of a previous PPG action plan. The group used this software to obtain feedback from PPG members around targeted questions about the services provided.

- Following PPG feedback about some aspects of the appointment system, the surgery had were undertaking a trial of a 'sit and wait' morning clinic on a Monday and Friday. The aim of this was to ensure all patients who needed to be seen could be seen so they did not have to phone the practice on another day to try and secure an appointment. The annual PPG report 2015 noted that this had proved very successful to date, and there were some planned changes to the running of this clinic to improve it further.

Continuous improvement

- There was a focus on continuous learning within the practice. Day to day operational management was in place to risk assess for continual improvements. Planned service developments to manage sustained growth of the practice were being considered such as succession planning for GPs and the recent introduction of an onsite pharmacy service to improve access in response to patient feedback.
- A practice nurse had recently reviewed the vaccine transportation practices in line with best practice guidelines and purchased the recommended vaccine cool bag.
- The practice was also working towards becoming a "Dementia friendly practice" following an initial meeting in January 2016 with the Alzheimer's Society and there were ongoing developments of the frailty service.