Addison House - Haque Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Requires improvement
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 Addison House Surgery on 21 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective and responsive services, and requires improvement for providing caring services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working aged people (including those recently retired and students), people whose circumstances make them vulnerable and people with mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded and monitored.
- Risks to patients and staff were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients said they were treated with empathy, compassion, dignity and respect. Patients did not always feel that they were listened to and involved in making decisions about their care and treatment.
- Information about services and how to complain was available and easy to understand. Complaints were mostly investigated and responded to in a timely and appropriate way.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Referrals to secondary care services were made appropriately however improvements were needed to ensure that referrals were made in a timely manner.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff were supported by management. The practice sought feedback from staff and patients. Improvements were needed to engage with patients to improve their experiences and levels of satisfaction.

Summary of findings

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

Importantly the provider should:

- Improve the systems for monitoring learning from incidents where things go wrong to help minimise the recurrence of significant events or incidents including delayed referrals and prescription errors.
- Ensure that staff who undertake chaperone duties complete training in respect of these duties.
- Ensure that regular infection prevention control audits are carried out to test the effectiveness of infection control within the practice.
- Ensure that staff follow policies and procedures around handling and storing vaccines.
- Ensure that all complaints are responded to in line with practice policies and procedures.
- Improve systems for patient engagement and responding to concerns so as to improve patient experience and levels of satisfaction.

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 understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. There were systems in place for acting on safety alerts and for sharing information with members of the staff team. Safety incidents and other incidents where things went wrong or near misses were investigated. Lessons were learned and communicated widely to support improvement. Improvements were needed to ensure that learning from when things went wrong was monitored and reviewed to minimise recurrence of certain incidents such as prescription errors and delayed referrals.

Staff were trained and able to recognise and report concerns around the safety and welfare of vulnerable adults and children. The practice had a chaperone policy in place and clearly displayed information informing patients how they could request a chaperone. Improvements were needed to ensure that all staff who performed these duties received training around their chaperoning roles and responsibilities.

Medicines were stored, handled and administered safely in line with current guidelines and legislation.

Risks to patients were assessed and well managed. The practice environment, and equipment used for diagnostic purposes and in the treatment of patients were maintained appropriately. Staff were recruited robustly and there were enough staff deployed to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data made available to us including comparisons to other GP surgeries within the area showed that most patient outcomes were at or above average for the locality in relation to assessing and treating patients with long term conditions, vaccination and screening programmes. Where areas for improvements were identified the practice worked collaboratively with the local Clinical Commissioning Group to achieve these.

Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely to plan patient care and treatment. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice regularly monitored patients with one or more long term condition and provided advice and guidance to promote good health.

Summary of findings

Staff had received training appropriate to their roles and any further training needs had been identified and suitable training and staff development was planned to meet these needs. There was evidence of appraisals and personal development plans for staff. The practice staff worked with multidisciplinary teams including community nurses, health visitors and social workers to improve outcomes for patients and ensure that they received coordinated care and support as needed.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Data showed that patients rated the practice lower than others in the area for several aspects of care. Patients who participated in the National GP Survey in November 2014 and published in January 2015 rated the practice lower than other practices in the local area for how they were treated by GPs and nurses, their involvement in their care and treatment and being listened to. The practice recognised that more work was needed to engage with patients and to improve their experiences and levels of satisfaction and was working with the local Clinical Commissioning Group to make improvements. As part of the improvement work the practice undertook to respond to comments made by patients on the NHS Choices website. There were a number of negative comments made by patients about their involvement in making decisions and patients feeling listened to and treated with care and concern. We saw that while the practice had responded to some of the comments made by patients the majority of comments had not been responded to.

Patients we spoke with during the inspection said they were treated with dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Patients whose first language was not English had access to language interpretation services to help them in understanding information about their care and treatment.

We also saw that staff treated patients with kindness and respect, and maintained confidentiality. The practice provided advice, support and information to patients, such as those with learning disabilities, mental health conditions and those with long term conditions.

The practice considered the needs of patients and their families when patients were receiving palliative care and nearing their end of their life. There were procedures in place to identify and act on patients' wishes and the practice worked proactively with other

Summary of findings

health care providers including community teams and the out-of-hours providers to enable patients to remain at home should they wish. The practice provided information, support and advice to families following bereavement.

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 monitored and changed access to services to meet these needs. The practice worked collaboratively with local charities and community to respond to the needs of patients who may experience difficulties in accessing services including the local travelling communities and homeless people.

Patients said they were happy with the practice opening times and they usually found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Patients experienced difficulties in accessing the practice by telephone and a new telephone system had been installed to improve telephone access. The practice engaged with patients and the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy to meet the individual needs of patients taking into consideration the health care needs of the local population. Staff and patients were aware of and were able to contribute to the practice values and vision. Staff we spoke with were clear about their responsibilities in relation to this.

There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to underpin and govern its activity and these were kept under review. Regular meetings were held with clinical and non-clinical staff to review, monitor and improve performance and outcomes for patients.

There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Participation Group (PPG) was active and two members of the group who we spoke with reported that the practice was open and proactive in dealing with

Summary of findings

comments and suggestions made by patients. Staff were supported to undertake their various roles within the practice and had received inductions, regular performance reviews and attended staff meetings and events.

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

This practice is rated as good for the care of older people. Patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment. The practice identified patients who were at risk of avoidable unplanned hospital admissions. These patients were included on the practice's 'unplanned admissions avoidance' list to alert staff to patients who may be more vulnerable. Regular multidisciplinary team meetings were held with other health and social care professionals to support patients and ensure that they received coordinated care and treatment.

The GPs carried out visits to patient's homes if they were unable to travel to the practice for appointments. The practice provided a range of health checks for patients aged 75 years and over. Seasonal flu vaccination and shingles vaccination programmes were provided and the practice was performing well in ensuring that patients received these.

Longer appointments were available if needed and a mini bus service was provided once a week to assist patients to attend the practice. The practice also provided medicines dispensing services and a medicines delivery service weekly to patients who were unable to attend the practice

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health and medication to ensure that their treatment remained effective. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. 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.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked online, in person or by telephone. Appointments could be booked up to two weeks in advance and telephone triage consultations were available daily.

Information and advice was available to promote health to women before, during and after pregnancy. A full range of pre-conception, antenatal and postnatal care services was available. The practice monitored the physical and developmental progress of babies and young children and weekly drop in sessions were held at the practice with the health visitor. Appointments for children were made available outside of school hours wherever possible.

There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed, including any issues shared and followed up, at monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for routine immunisation and vaccination programmes.

Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group 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. Appointments could be booked online, in person or by telephone. Appointments could be booked up to two weeks in advance and telephone consultations were available daily. Pre-booked appointments were available on Saturdays between 9am and 1pm.

Summary of findings

Information about five yearly health checks for patients aged between 40 and 75 years was available within the practice and on their website. Nurse led clinics were provided for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the various vaccinations available including diphtheria, tetanus, polio and hepatitis A was available on the practice website. When patients required referral to specialist services, including secondary care, patients were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice recognised the needs of people who were vulnerable such as travelling communities and homeless people, those with depression, alcohol or substance misuse issues, people with mental health conditions and those with learning disabilities. The practice worked with the health visiting team to engage with travelling communities and promote health screening and childhood immunisations.

The practice also worked with local charities that supported homeless people and children and young people affected by domestic violence. Some nursing staff had undertaken training in supporting and treating patients with learning disabilities and learning difficulties and patients with learning disabilities were invited to attend for an annual health check and staff worked proactively to improve the uptake of these checks.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations such as MIND. 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with

multidisciplinary teams to support people experiencing poor mental health including those with dementia. The practice had recently commenced dementia screening services and referrals were made to specialist services as required.

The practice had suitable processes for referring patients to appropriate services such as psychiatry and counselling, including The Improving Access to Psychological Therapies (IAPT) and referrals to Child and Adolescent Mental Health Services (CAMHS) as required.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations and services. Patients were referred to local counselling sessions where appropriate and patients were provided with information on how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by reviewing data available from NHS Choices and the National GP Patient Survey results from 2014 (published in January 2015). Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received.

We reviewed the findings of the NHS England National Patient Survey 2014 for which there were 129 responses from the 432 questionnaires distributed to patients (30%) of those people contacted. The practice performed in line with or above average within their Clinical Commissioning Group in relation to patients' satisfaction with the practice opening times, helpfulness of reception staff and reporting that GPs listened to them. Patients were less satisfied with waiting times to see GPs, being involved in making decisions about their care and treatment about their treatment. Overall 52% of patients would recommend the surgery to someone new in the area. This was significantly lower than the local Clinical Commissioning Group average of 73%.

Patients who participated in the NHS England National Patient Survey 2014 (published in January 2015) also expressed lower levels of satisfaction in areas around being listened to and being involved in making decisions about their care and treatment. For example 17% of patients reported that they were able to see or speak with their preferred GP. The national average was 38%. Approximately 55% of patients said that their GP was good at involving them in making decisions about their care and treatment and 62% said that their GP was good at treating them with care and concern. These results were significantly lower than the national average levels of satisfaction.

We received nine completed 'Tell us about your care' comment cards. All of the patients who completed these expressed satisfaction with the care and treatments and service they received. They commented that staff were polite, kind, caring and helpful. The majority of patients told us that they were happy with access to the practice and the appointments system. Three of the nine patients who completed comment cards told us that they often experienced difficulties in accessing appointments. A number of patients said that they could access same day appointments.

We also spoke with eight patients on the day of our inspection, two of whom were involved with the practice Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients were positive about their experience of being patients at the practice. They told us that they were treated with empathy and with respect and the GPs, nurses and other staff were professional, kind, sensitive and helpful.

Areas for improvement

Action the service SHOULD take to improve

- Improve the systems for monitoring learning from incidents where things go wrong to help minimise the recurrence of significant events or incidents including delayed referrals and prescription errors.
- Ensure that staff who undertake chaperone duties complete training in respect of these duties.
- Ensure that regular infection prevention control audits are carried out to test the effectiveness of infection control within the practice.
- Ensure that staff follow policies and procedures around handling and storing vaccines.
- Ensure that all complaints are responded to in line with practice policies and procedures.
- Improve systems for patient engagement and responding to concerns so as to improve patient experience and levels of satisfaction.

Addison House - Haque Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Addison House - Haque Practice

Addison House Surgery is located in a purpose built health centre on the outskirts of Harlow Town Centre. The practice provides services for approximately 13,000 patients living within the Harlow covering the area including Lower Sheering, Stanstead Abbot and Nazeing. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by West Essex Clinical Commissioning Group.

The practice population is higher than the national average for older people over the age of 75 years and younger people and children under four years. Economic deprivation levels affecting both children and older people were slightly higher than the practice average across England. Life expectancy for men and women were just above the national averages. Their patients had slightly lower than average long standing health conditions and national average for disability allowance claimants.

The practice is managed by four GP partners who hold financial and managerial responsibility for the practice. The practice employs three salaried GP's, two nurse practitioner, one practice nurse and two health care assistants, a practice manager, deputy practice manager and a team of administrative, secretarial and reception staff who support the practice.

The practice is open between 8.30am and 6.30pm on weekdays with surgeries running from 9.30am to 12.20pm and 3.30pm to 5.20pm daily and pre-booked routine appointments are available on Saturday mornings between 9am and 1pm.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings, weekends and public holidays. Patients who contact the surgery outside of opening hours are directed to the NHS 111 service where they are referred to the out-of-hours GP, hospital A&E or minor injuries department as appropriate.

Why we carried out this inspection

We inspected Addison House Surgery as part of our 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.

Detailed findings

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?

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations including NHS England and West Essex Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 21 April 2015. During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, reception and administrative staff. We reviewed policies, procedures and other documents in relation to the management and day-today running of the practice. We spoke with patients who used the service. We talked with carers and family members. We reviewed comment cards, NHS Choices and National GP Patient Survey results where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that they were supported to raise concerns and that the procedures within the practice worked well.

There were systems for dealing with the alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA). These alerts have safety and risk information regarding medication and equipment, often resulting in the review of patients prescribed medicines and/or the withdrawal of medication from use and return to the manufacturer. The practice manager told us that MHRA and other relevant alerts were forwarded to GP partners for review and that these were then shared with staff through the practice electronic system. Records showed that if the alert related to a specific medication or treatment, a GP reviewed patient and checked the appropriateness of the treatments and risks. GPs amended the patient's treatment and substituted medicines with alternatives where this was indicated.

There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. We saw evidence that these were shared with staff and actions taken as necessary to improve safety outcomes for patients.

Complaints, accidents and other incidents such as significant events and near misses were reviewed at the weekly Monday staff meetings to monitor the practice's safety record and to take action to improve on this where appropriate. We reviewed safety records, incident reports and minutes of meetings where these had been discussed during the last 12 months. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents, accidents and near misses. Staff we spoke with said that they would record, and report any significant or untoward event to their line manager. We saw that reporting forms were available on the computerised system and hard copies were also available and staff were aware of where to find these. We saw that staff were proactive in reporting incidents where things went wrong and near misses. Staff told us that incidents were discussed at weekly Monday staff meetings, which staff told us were useful in ensuring that relevant information and learning was shared. Minutes from these meetings confirmed that incidents, concerns and complaints were discussed openly and that learning points were shared.

We looked at records in respect of incidents, which had occurred within the previous twelve months. A total of 24 significant events had been reported. Five of these related to delayed or missed referral. Issues in relation to failures in communication were identified when these events were investigated and improved systems for checking referrals had been implemented. Other incidents and events related to incorrect information given to patients or recorded in patients' notes, medication prescription errors and two issues in relation to the storage and administration of vaccines. We saw that these incidents had been investigated in an open and transparent way and learning was shared among staff. However, there had been a number of recurrences of similar incidents reported such as delays in referrals and medicines related incidents and the practice would benefit from a system for periodically reviewing the measures in place to minimise incidents to ensure that learning from incidents was imbedded in practice.

Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong or where there were near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved. Staff we spoke with were aware of and could tell us of changes that had been implemented following serious or significant incidents. For example receptionist and administrative staff told us of learning and changes in procedures for making referrals following a number of incidents where these were delayed due to issues such as making requests for referrals using incorrect referral forms.

Good

Are services safe?

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Patients we spoke with during our inspection and those who completed comment cards told us that they felt safe and that they had no concerns. We looked at training records which showed that all staff had received relevant role specific training on safeguarding adults and children. We saw that some staff had not undertaken training within the previous 12 months and updates were planned for staff as needed. Staff we spoke with knew how to recognise signs of potential abuse or neglect in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information with the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff.

The senior GP partner took the lead in safeguarding for adults and children. Records we viewed showed that they had been trained to the appropriate level in safeguarding children. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. GPs were appropriately using the required codes on their electronic case management system to ensure risks to vulnerable adults and children and young people who were looked after (under the care of the local authority / in foster care) or on child protection plans were clearly flagged and reviewed. Information in relation to risks and vulnerabilities was recorded within the practice computerised system and used to make staff aware of any relevant issues when patients attended (or failed to attend) appointments. We saw that information was also reviewed and shared with staff at the weekly Monday staff meetings. The GP who led on safeguarding was aware of vulnerable children and adults. Records demonstrated how they had previously worked with partner agencies such as the police and social services where concerns about patients had been identified. Records showed that information was shared with appropriate agencies including local social services, the police and health visitors as appropriate.

The practice had a chaperone policy, which was available and easily visible in the waiting room and consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice manager told us that where possible chaperone duties were carried out by nursing staff and only where this was not possible that health care assistants or administrative staff would perform these roles. Records we viewed showed that staff criminal records checks had been carried out through the Disclosure and Barring Service (DBS) for staff who carried out chaperone duties. Records we views and discussions with staff confirmed that staff had not undertaken training around chaperone duties and responsibilities. Staff we spoke with had an awareness of their responsibilities when acting as chaperones.

Patients' individual records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals, out-of-hours providers and community services. We saw evidence that staff had undertaken training in the use of the electronic system and audits were carried out to assess the completeness of these records. Action had been taken to address any shortcomings identified.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There were procedures in place to ensure that medicines were stored at the appropriate temperature so that that they remained effective. The temperatures of fridges used to store medicines were monitored daily to show the maximum, minimum and actual temperature. This helped to help identify any issues with the storage of medicines such as vaccines and other medicines which require cold storage to ensure that they did not exceed those recommended by the medicine manufacturer.

The practice had policies and procedures in place for the receipt, handling and storage of temperature sensitive medicines such as vaccines to ensure that medicines remained effective and suitable for use. Staff who we spoke with demonstrated that they understood these procedures. However, on the day of our inspection we saw that a small number of vaccines were left out of the fridge in one treatment room and the nurse we spoke with told us that these were to be used for the afternoon immunisation clinic. It was not clear how long medicines had been stored outside of the fridge, however they appeared to be at room

temperature and therefore may not be fit for use. We spoke with the practice manager and other nurses and they confirmed that this was not common practice and assured us that procedures would be monitored more robustly to ensure that staff followed these consistently.

Processes were in place to check medicines were within their expiry date and suitable for use. Records were maintained to show that these checks were carried out regularly. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses administered vaccines using directives that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directives and evidence that nurses had received appropriate training to administer vaccines.

We saw the practice held regular medicines management meetings and monthly prescribing meetings to review and monitor their prescribing practices. There were suitable procedures for reviewing patients' medicines and repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled safely.

The GPs discussed the arrangements for the management of high risk medicines which may have serious side-effects. GPs told us that patients who were prescribed these medicines had regular blood tests carried out and that these were reviewed when authorising repeat prescriptions.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and that when their prescriptions were reviewed and any changes were explained fully. Patients we spoke with and those who completed comment cards told us that that the repeat prescription service generally worked well and they had their medicines in good time. However from records of significant events we saw showed that there were incidents of prescription errors with patients having been given incorrect prescriptions or advice about their medicines. We found that these incidents had been investigated and appropriate action had been taken.

Cleanliness & Infection Control

The practice had policies and procedures in place to protect patients and staff against the risk of infections.

Patients we spoke with during the inspection told us that they found the practice was always clean and that they had no concerns. We observed the premises to be visibly clean and tidy. Hand sanitising gels were available for patient use. Hand washing sinks with liquid soap, sanitising gel and paper towel dispensers were available in treatment rooms and toilet facilities, as were posters promoting good hand hygiene.

We saw there were cleaning schedules in place for daily, weekly and periodic cleaning tasks for general and clinical areas. Cleaning records were kept to show when cleaning had been carried out. The practice had arrangements for monitoring the infection control procedures. However, regular infection control audits were not carried out to test the effectiveness of the procedures in place to protect staff and patients against the risks of infection. We saw that the most recent audit had been carried out in April 2015 and prior to this the last audit was carried out in 2013. There was an action plan in place to deal with areas for improvements identified in the 2015 audit and we saw evidence that issues were being managed and rectified in a timely way.

There were infection control policies and procedures for staff to follow, which enabled them to plan and implement control of infection measures. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. Staff were provided with appropriate personal protective equipment including disposable gloves and aprons. Spillage kits were available for cleaning and disposing of body fluids and staff we spoke with were aware of where to locate these when needed. We saw records to confirm that patient disposable privacy curtains were changed on a regular basis. The practice provided minor surgical procedures such as excision and biopsy of skin lesions and joint injections. We saw that single use disposable instruments were provided for all minor operations they performed and staff were trained in aseptic technique to minimise the risks of infections. We saw that audits were carried out in respect of surgical procedures to help monitor and minimise the risks of infections.

We saw that the practice had arrangements to segregate and safely store clinical waste at the point of generation until it was disposed of. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles. These were

suitably located, labelled and not overfilled. Clinical waste was stored in a dedicated secured area and the practice had a contract with an appropriate waste disposal company for regular collection of clinical waste matter.The nurse practitioner took a lead role for infection control. From records viewed we saw that they had undertaken further training to enable them monitor and oversee the infection control procedures within the practice. We saw evidence that the majority of staff had undertaken infection control training within the previous 12 months and training updates were planned for staff as needed. Records showed that all clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections

Staff recognised patients who may be more vulnerable and susceptible to infections, such as babies, young children, older people and patients whose immune systems may be compromised due to illness, medicines or treatments. Advice and information was provided so as to help patients protect themselves against the risks of infections. Information and advice was available about the Ebola virus and what they should do should they or someone they knew experienced potential symptoms of the virus.

The practice had conducted a risk assessment to identify and manage the risks associated with legionella (a germ found in the environment which can contaminate water systems in buildings).

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of diagnostic and screening procedures, such as blood tests, respiratory, diabetes and well person procedures. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. Records we viewed showed that relevant equipment such as weighing scales, spirometer, thermometers, ear syringe and the fridge thermometer were calibrated in line with the manufacturer's instructions so as to ensure that this equipment was fit for use. Through discussion with staff and a review of records we saw that equipment was replaced as needed.

Staffing & Recruitment

The practice had suitable and robust procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. These set out the processes for assessing a person's suitability to work within the practice, including carrying out criminal records checks and obtaining employment references. We reviewed five staff records for staff including GPs, nurses and administrative staff. Records included proof of identification and evidence of each person's qualifications and registration with the appropriate professional body, such as the Nursing and Midwifery Council (NMC) for nurses and the General Medical Council (GMC) for GPs where appropriate. We saw that appropriate references had been obtained for all staff. Criminal records checks through the Disclosure and Barring Service (DBS) had been carried out for all clinical staff. These had not been carried out for administrative or reception staff and the practice manager told us that a risk assessment was being conducted to identify if these were needed.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The senior partner told us that there was a low turnover of staff, which helped the practice with continuity of care. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice ensured that only one GP took planned leave at any one time and where appropriate locum GPs were employed. There were also arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and to cover for periods of unplanned absence due to illness.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had experienced staff shortages within the previous year due to staff absence. The manager showed us records to demonstrate temporary agency and locum staff were employed to cover these shortages and that actual staffing levels and skill mix were in line with planned staffing requirements. These were regularly reviewed to ensure that they met the needs of patients.

Good

Are services safe?

Monitoring Safety & Responding to Risk

The practice had a health and safety policy, which staff were aware of. Risks were identified through a variety of assessments, which covered areas such as premises, medicines management, staffing levels and untoward issues which may impact on the running of the practice. These assessments were, monitored and audited to ensure that the practice environment, equipment and staff practices were safe.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they were aware of these procedures. For example staff had access to policies and procedures for treating sudden deterioration in patients including children and treating patients in the event of a mental health crisis. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency medicines and equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When asked, all members of staff knew the location of this equipment. Records we viewed confirmed that this equipment was checked regularly. There were protocols in place for dealing with medical emergencies including the treatment of cardiac arrest, anaphylaxis and hypoglycaemia and appropriate medicines were available. Anaphylaxis kits were available to treat patients in the event of allergic reaction to medicines. Staff were able to describe how they would act in the event of patients requiring emergency treatment and how they supported these patients.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice such as loss of power, adverse weather conditions, staff shortages or other circumstances that may affect access to the building or a disruption of the service. The plan was available in a folder at reception and at various points throughout the practice. Staff we spoke with were aware of the plan and who to contact should the need arise. We saw that the plan contained relevant details and contact numbers to assist staff. Any changes to the plan were communicated at the weekly practice meetings and through email communications.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that the majority of staff were up to date with fire training and updates were planned for staff as needed. Records showed that fire equipment was inspected periodically to ensure that it was in safe working order. Fire evacuation procedures were displayed throughout the practice and staff were aware of the procedures to evacuate the premises in the event of a fire or other incident.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We saw that patient care and treatment was delivered in line with recognised best practice standards and guidelines. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to patient care and treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), Clinical Commissioning Group guidelines and policies. Staff told us that information and any changes in legislation or national guidelines were shared during regular clinical staff meetings. Records we viewed confirmed this. New patients were offered appropriate health checks when they joined the practice and staff proactively contacted patients where appropriate to attend for regular health checks and reviews.

The GPs told us there was a lead GP for a number of long term conditions, for example heart disease, gastro-intestinal disorders, antenatal and baby care and diabetes. They served as a source of expertise for colleagues in the practice and were responsible for ensuring new developments or specific clinical issues were discussed at the relevant practice meetings. There were a number of clinics held at the practice including those for asthma and chronic obstructive airways disease, family planning, minor surgery and diabetes. The nurse practitioner and practice nurses supported this work through nurse led clinics which allowed GP's to focus on patients with more complex healthcare needs.

All GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. We saw minutes of meetings where regular reviews of elective and urgent referrals were made and that where improvements to practice were noted these were shared with all clinical staff. The practice made effective use of the specialist knowledge and expertise of the GPs at the practice. For example, regular discussions were held between GPs to discuss patient care and appropriate pathways for medical conditions such as diabetes and gastro-intestinal conditions to help manage the number of referrals made to secondary care services where appropriate.

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 and the practice took account of patient's age, gender, race and culture as appropriate.

Staff told us that information relating to patients who accessed the out-of-hours services and patients' test results were reviewed by GPs on a daily basis. We saw evidence that when patients were discharged from hospital, their patient records were sent to the patient's GP for review and that any changes to medication or ongoing treatments were recorded appropriately.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, summarising patients' records, managing child and adult protection alerts and medicines management. Information was shared widely with staff and other healthcare professionals. There was evidence of effective structuring of patient records undertaken by clinicians. This included the use of templates to ensure that care and treatment provided was comprehensive, standardised and took into account best practice guidance.

The practice participated in all the enhanced services from the Clinical Commissioning Group (CCG), Public Health and NHS England. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Data we reviewed showed that the practice's performance in assessing and treating the majority of patients with long term conditions such as diabetes, asthma, chronic respiratory diseases and heart disease were generally in line with or just below that the local Clinical Commissioning Group (CCG) and national averages. Improvements were needed in the monitoring and reviewing of patients with diabetes and atrial fibrillation (an irregular heartbeat associated with certain cardiac conditions). For example the percentage of patients with diabetes who had a

creatinine : albumin ratio test within the previous 12 months was 53%. The national average was 86%. These tests help to identify early signs of kidney disease which is associated with diabetes. The practice was working with the local CCG to secure the necessary improvements.

Good

Are services effective?

(for example, treatment is effective)

The practice reported some variable performance for diabetic health checks and reviews within the previous 12 months. GPs attributed this in some part to nurse staff shortages with one nurse on maternity leave and one resigning from their post. They told us that while cover was provided by temporary agency nurses that this had impacted on carrying out some health checks and patient reviews. They had also identified that some continuity of care was lost where patients did not see the same GP for their reviews and in an attempt to improve in this area GPs had started to book in appointments for reviews to help ensure that patients were seen by the same GP. Data we viewed and through discussion with GPs and nurses we saw that the practice had made improvements within the previous months. We found that the practice was performing in line with local and national targets for the uptake of all childhood vaccinations and immunisations, flu vaccinations and women's cervical screening.

The practice had a system in place for carrying out clinical audits, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. We looked at one clinical audit which was being carried out at the time of our inspection. The audit reviewed the practice prescribing medicines in the treatment of gastric reflux and stomach ulcers with medicines to prevent blood clots in patients following heart attacks and those with other cardiac conditions where there are increased risks of blood clots. These medicines are often co-prescribed. Research has suggested that the combination of these medicines may reduce the effectiveness of medicines to help prevent blood clots. The audit identified patients who were prescribed both medicines and the gastro-protective medicines were stopped. Patients were being monitored to assess the effectiveness and to monitor risks of gastro-intestinal disturbances. A second audit had been undertaken to identify risks of gestational diabetes in pregnant women and had resulted in increased blood glucose monitoring in patients who were risks were identified.

The practice protocol for repeat prescribing was in line with national guidance and staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also monitored the routine health checks carried out for patients with long-term conditions such as diabetes, asthma and chronic heart disease and for patients with learning disabilities and those with mental health conditions.

The practice kept a registers of patients with learning disabilities, those receiving palliative care and patients who were identified as vulnerable or at risk of unplanned hospital admissions. The practice held weekly multidisciplinary meetings which were well attended by external professionals such as the community nursing team to help ensure that patients were treated and supported appropriately according to their assessed needs.

Effective staffing

The practice employed staff who were suitably skilled and qualified to perform their roles. Records we viewed showed that appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We spoke with staff and reviewed staff records and saw that the majority of staff were up to date with training including annual basic life support, infection control and fire safety. We saw that there was a training plan in place which identified staff who were due training updates and that these were planned for. The practice consisted of four GP partners and three salaried GPs. All GPs were up to date with their yearly continuing professional development requirements. One GP had completed their revalidation within the previous five years and all others were working towards this. (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).

Staff including practice nurses and health care assistants had clearly defined roles within the practice and were able to demonstrate that they were trained to fulfil these duties. All staff undertook annual appraisals of their performance from which learning and development needs were identified. Records viewed showed that staff had individual personal development plans in place. Staff we spoke with were positive about the peer support arrangements and working relationships between all members of staff within the practice. The practice also had systems in place for identifying and managing staff performance and providing support and further training to assist staff should they fail to meet expected standards.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patients' needs and support patients with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out of hour's providers and the 111 summaries were reviewed and actioned on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held weekly multidisciplinary team meetings to which the relevant community health and social care professionals were invited to review and plan care and treatment for patients such as those who with life limiting illnesses and vulnerable patients. Staff felt that these worked well and were used to make appropriate referrals to social and community services. The practice had an established system for patient referral to external services for assessments, treatment or advice. Staff reported that they worked well with the local out-of-hours provider to share up to date information in relation to the needs of people who were receiving palliative care was shared so as to ensure that these patients received appropriate care according to their changing needs.

The practice manager and GPs also engaged with other locality managers through meetings held on a two monthly basis for support and advice on issues relating to primary medical services. However the practice manager confirmed that their attendance at these meetings had been limited due to time constraints.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. However some limitations with the electronic system had been identified and the practice was due to move to another electronic system in the near future.

The practice used several electronic systems to communicate with other providers. For example, there were facilities for sharing patient records between GP practices when a patient registered or deregistered and the community nursing team and health visitors had access to the patient records where patients had consented to the sharing of their medical information. Electronic systems were also in place for making referrals to secondary care services such as specialist consultants. Staff reported that the systems were easy to use.

The practice had ensured the electronic Summary Care Records were completed and accessible on line. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or outside of normal hours. Information about the sharing of patient information was available on the practice website and in written leaflets which were readily available.

Consent to care and treatment

The practice had policies and procedures in place for obtaining a patient's consent to care and treatment where patients were able to give this. The policy covered documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Consent procedures included information about people's right to withdraw consent.

GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patient's consent before carrying out physical examinations or providing treatments. Patients we spoke with confirmed that their treatment, options available, risks and benefits had been explained to them in a way that they could understand. They told us that their consent to treatment was sought before the treatment commenced.

Staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties to meet the requirements of these legislations when treating patients. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Good

Are services effective?

(for example, treatment is effective)

Patients with a learning disability and those with dementia who were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing, where they were able to do so. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room with dedicated patient information boards. Information was also available on the practice website and this was regularly updated. These included information to promote good physical and mental health and lifestyle choices. Information available included advice on diet, smoking cessation, alcohol consumption and substance misuse. There was information available about the local and national help, support and advice services.

Information about the range of immunisation and vaccination programmes for children and adults, including MMR, Shingles and a range of travel vaccinations were well signposted throughout the practice and on the website.

The practice offered a full range of health checks. All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice had identified and offered appropriate smoking cessation support to patients. The practice recorded information about health promotion within patients' records through the use of specific health promotion templates.

Data we viewed for 2013/14 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests) and annual health checks for patients with one or more long-term health condition such as diabetes and respiratory diseases. At the time of our visit we saw that the practice was monitoring its performance for 2014/15 and were proactively targeting patients who had failed to attend appointments for healthcare screening, immunisations and annual health checks.

Requires improvement

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with during our inspection commented that all staff were caring and that staff listened to them and took their views and concerns into consideration. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the November 2014 National GP Patient Survey (published in 2015), and a survey of patients undertaken by the practice in 2014. We saw that the practice performed significantly lower than the national average for patients expressing overall satisfaction with approximately 59% of respondents indicating overall satisfaction with the practice. The local average was 86%. From this survey we saw 86% of patients who responded said that the receptionists were helpful, which was similar to local averages. 62% said the last GP or nurse who they saw were good at treating them with care and concern in comparison to the local Clinical Commissioning Group average of 85%. We saw that 62% said that their GP was good at treating them with care and concern. This result was significantly lower than the national average levels of satisfaction which sat at 86%.

The results from the practice survey which was carried out in 2013/14 were more positive with 94% of patients reporting that receptionists were helpful and 96% saying that GPs and nurses were caring. Following an analysis of both the national and practice survey an action plan was implemented to help address some of the issues of patient dissatisfaction. These included looking at ways to engage more with patients and to provide more information about the services provided to help patients gain a better understanding of for example the telephone consultation system to help allay anxieties.

Patients completed CQC comment cards to tell us what they thought about the practice. We received nine completed cards and all were positive about the care they received and how they were treated by staff. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring, kind and compassionate. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. We reviewed complaints received in 2014/15. These had been analysed by the practice and we found that 14 complaints related to communication and the attitude of staff, with some patients complaining that staff were rude or dismissive. We saw that these had been investigated and that learning had been shared with staff. Customer care training was also planned for all staff to help improve patient experience. The practice was working with the local Clinical Commissioning Group (CCG) and an action plan had been developed to improve patients experience and levels of satisfaction. As part of this plan the practice undertook to respond to comments made by patients on the NHS Choices website. We reviewed this and found that while there were some responses from the practice the majority of comments had not been responded to.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The waiting area was open plan and staff were careful not to repeat personal information when speaking with patients on the telephone. Private facilities were available to speak with patients away from the public reception area to maintain patient confidentiality. We also saw that there were arrangements in place for the secure disposal of confidential records and information through a commissioned service.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. There was a policy and procedure in place to support and manage patients who displayed abusive behaviour. Staff told us how they would try to immediately diffuse the situation and accommodate patients' needs wherever possible.

Care planning and involvement in decisions about care and treatment

Seven patients we spoke with on the day of our inspection told us that they felt they were listened to and involved in

Requires improvement

Are services caring?

discussions about their care and treatment. They told us told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive.

We reviewed information from the 2014 National GP Patient Survey (published in 2015). This showed the practice performed below the local Clinical Commissioning Group (CCG) average for patient's satisfaction in relation to their involvement in their care and treatment. 62% of patients who responded to the survey said that GPs and nurses were involving them in decisions about their care. The local CCG average was 85%. From the survey we saw that 77% of patients felt that GPs and nurses were good at listening to them. This was also lower than the local CCG average of 86%. The GP partners acknowledged that the practice had not always engaged with patients and that there was work to do in improving patient's experience and satisfaction in these areas. The senior GP partner told us that they were reviewing ways of improving communication with patients.

The practice had considered the needs of the local population group and had identified patients from ethnic minorities and those whose first language was not English. Staff told us that language interpretation services were available and they knew how to access these. They also told us that they actively engaged with patients from the travelling communities in the area and worked effectively with the health visitors to improve patient's access to the practice within this population group.

Patient/carer support to cope emotionally with care and treatment

Patients who we spoke with during the inspection told us that staff were caring and that they offered emotional support as needed. We saw that the practice worked proactively with other health and social care providers including local hospice services to enable patients who wished to remain living in their homes when their health deteriorated. GPs and community staff told us that they worked well to support patients' changing needs in relation to end of life care and treatment and that supporting patients to stay in their preferred place. We saw that patients receiving palliative care had care plans, which were shared with relevant health care providers, including the out-of-hours service to ensure that patients received appropriate care as they approached their end of life. The practice had procedures for supporting bereaved families. Staff told us that if families had experienced bereavement, their usual GP contacted them by telephone and appointments or home visits were arranged as needed.

The practice had policies and procedures in place for identifying and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified at registration we were shown the written information available for carers to ensure they understood the various avenues of support available to them. Information in the patient waiting room, told patients how to access a number of support groups and organisations within the local area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it served and acted on these to plan and deliver appropriate and responsive services. The practice acknowledged that improvements were needed and told us of some of the challenges they faced. They reported an increase in patient numbers from 9,000 to 15,000 in the previous years due to 30 to 40% increase in housing developments in Harlow. The practice population was higher in numbers of young people and older people over the age of 75 years. The practice recognised the need to engage more with patients and was looking at ways to develop the Patient Participation Group (PPG) so that this reflected the population more representatively. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

Patients were registered with a named GP and we saw evidence of continuity of care which was provided by that approach. Patients who needed to be seen urgently were not always able to be seen by their named GP although this was encouraged for routine appointments. We saw that some GPs booked appointments for patients to help improve continuity of care. Patients could choose to be registered with a male or female GP according to their preference. Longer appointments were available for people who needed them, which included patients with a learning disability. Home visits were available to patients who were unable to attend appointments at the practice because of illness or disability.

The practice was working with the local Clinical Commissioning Group to make improvements in responding to the needs of patients and work was being undertaken to improve access to services and appointments.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. The practice population included patients from travelling communities and homeless people. GPs told us that they worked collaboratively with the local health visiting team to support patients from the travelling communities. Health visitors could book appointments for baby immunisations and patients could access same day appointments as needed. The practice recognised the needs of patients who were homeless or resident in temporary accommodation such as hostels and refuges. They worked with the local 'Streets to Homes' charity which provided a range of practical services, employment and accommodation advice to homeless people. The practice also supported children and young people who were affected by domestic abuse and provided on the day appointments to patients who used the services of Acasia House, part of the Safer Places charity. Patients who had learning disabilities were supported to access services. Some nursing staff including the advanced nurse practitioner had undertaken training and had experience in caring for people with learning disabilities.

The practice had policies and procedures for promoting diversity and equality. The majority of patients at the practice spoke English as their first language. The practice had access to online and telephone translation services if required. A hearing loop system was available to support patients who used hearing aids and devices.

The premises and services were suitable to meet the needs of patient with disabilities for example the entrance was accessible via an automatic door. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice as well as baby changing facilities.

Access to the service

Patients we spoke with during the inspection and those who completed comment cards told us that they could usually get an appointment with their preferred GP and same day appointments for urgent treatments if needed. Three of the nine patients who completed comment cards reported some difficulty in getting appointments with their preferred GP. These levels of patient satisfaction were also reflected in the results of the National GP Patient Survey 2014 (published in 2015). We saw that 79% of patients who responded to the survey and who had a preferred GP said that they usually got to see or speak with this GP, 70% said that they were overall happy with the practice opening hours. These results were in line with other GP practices in the local Clinical Commissioning Group (CCG) averages for patient satisfaction.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had introduced an open surgery system in an attempt to improve access to appointments for patients. However, this had resulted in an increase in complaints from patients around waiting times. This was also reflected in the National GP Patient Survey 2014 where 23% of patients who responded to the survey reported that they waited 15 minutes or less after their appointment time to see a GP. This was lower than the CCG average of 58%. As a result of patient responses the practice re-introduced the appointment booking system. We saw that they also routinely monitored the number of appointments where patients failed to attend or cancel and were looking at ways to reduce this from the current level of 11%.

Patients reported difficulties in accessing the practice by telephone. 41% of patients who completed the GP survey said that they found it easy to get through to the practice by telephone against the local Clinical Commissioning Group average of 75.4%. A new telephone system was installed in the practice in December 2014; however there had been some issues with this and these were being addressed to improve the efficiency of the telephone access services.

The practice was working with the local CCG to make improvements in patient satisfaction around access to the service. West Essex CCG has identified Addison House as a pilot site for a GP Wellness hub in 2015/16. The hub will include volunteers based in the practice working with the practice team to assist in directing patients to local services where this is more suitable than a GP appointment. The practice had also submitted a bid for funding for a 'self-care' digital service could choose from a range of services based upon their needs.

The practice was open between 8.30am and 6.30pm on weekdays with surgeries running from 9.30am to 12.20pm and 3.30pm to 5.20pm daily and pre-booked routine appointments were available on Saturday mornings between 9am and 1pm. The practice operated a duty GP system each day with an allocated GP available to see patients in an emergency and to conduct telephone consultations.

Details about how to make, reschedule and cancel appointments was available to patients on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice website provided information about the availability of GPs, some of whom worked part time and the website informed patients of days when GPs were unavailable. Appointments could also be booked via mobile telephone applications using 'smartphone' technology.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns & 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.

We saw that information was available to help patients understand the complaints system in posters displayed in patients waiting areas, within the practice leaflet (available in print and online) and in a complaints leaflet. This information included details of how a complainant could escalate their concerns to the NHS England and the Health Services Ombudsman, should they remain dissatisfied with the outcome or if they felt that their complaints had not been dealt with fairly. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Patients we spoke with said that they had not needed to make a complaint about the practice.

We looked at a sample of complaints received by the practice for within the past 12 months. We found that the patients concerns had been fully investigated and a response was sent to the patient, outlining the outcome of the investigation and offering apologies where this was indicated. We saw that the majority of complaints had been investigated and responded to within the timescales as set out in the complaints procedure. However the practice had been issued with a breach of their NHS England contract in January 2015 part for failure to respond to the specific concerns raised by a patient and failing to respond to NHS England within the set timescales. The practice had since responded to the issues identified and NHS England were reviewing this at the time of our inspection.

We saw that complaints and concerns were reviewed periodically to identify any themes or trends in patient

Good

Are services responsive to people's needs?

(for example, to feedback?)

dissatisfaction. We saw that complaints and concerns were reviewed periodically to identify any themes or trends in patient dissatisfaction From the most recent analysis of complaints, which was carried out in March 2015 we saw that there were trends and themes arising from complaints had been identified and reviewed such as attitude and perceived rudeness of some staff. The senior GP told us that customer care training was planned for staff so as to improve patient's experience.

From records we viewed and through discussions with several members of staff we found that patients complaints and concerns were discussed at staff meetings, where learning and changes to practices were shared. Staff we spoke with told us that they were able to contribute ideas and suggestions for improving practice where things went wrong.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver and maintain high quality care and meet the individual needs of patients. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. The practice philosophy was described in the patient information leaflet and on the practice website. The practice had systems for discussing and reviewing future planning and strategy, through clinical and non-clinical staff meetings, which it reviewed regularly.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had was making changes accordingly through work with the local Clinical Commissioning Group, conducting reviews and listening to staff and patients.

Governance Arrangements

The practice had a number of policies and procedures in place to govern its activity and these were available to staff. We looked at a sample of these policies and procedures, including those related to medicines management, infection control, staff recruitment and training, fire safety and patient confidentiality. All policies we viewed were up to date and subject to regular review to ensure that they were relevant and developed with local and national guidelines. Staff we spoke with said that they had access to and understood the policies and how they related to their various roles within the practice.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. Other GP partners had specialist interests in areas such as endocrinology, diabetes care and antenatal care. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The QOF data for this practice showed it was performing above or in line with national standards in most areas. The practice performance was lower than expected for some aspects of managing and monitoring conditions such as diabetes and atrial fibrillation. The practice was working with the local CCG in line with an action plan to help secure improvements. We saw that QOF data was regularly discussed at weekly team meetings to maintain or improve outcomes.

A number of clinical audits were carried out in the practice. While these audits had not completed full cycles we saw evidence that they were used to monitor patient treatment and that changes were made to medicines and treatment practices in line with changes to national and local guidelines. From a review of records including minutes from staff meetings, appraisals, complaints and significant event recording we saw that information was regularly reviewed to identify areas for improvement and to help ensure that patients received safe and appropriate care and treatments.

Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were supportive and approachable. GPs told us that the senior partner was proactive and they spoke very highly about how they promoted transparency within the practice. All staff we spoke with told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held a range of weekly clinical and non-clinical staff meetings to discuss any issues or changes within the practice.

Seeking and acting on feedback from patients, public and staff

The practice sought feedback from patients on a regular basis. The practice had an active Patient Participation Group (PPG). A PPG is made of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services

Are services well-led?

Good

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

provided and, over time, commissioned by the practice. We spoke with two members of the PPG and they told us that the practice was open to and acted on, where possible, the suggestions made by the group. They told us that the group met regularly and that patients who wished to participate but were unable to attend meetings could contribute virtually by email. The PPG carried out patient surveys and the results from these were made available to patients, as they were displayed in the patient waiting area and on the practice website. The results from the most recent survey, carried out in 2014 showed that patients were satisfied with the services they received at the practice. The results of the survey identified areas where improvements were needed such as answering telephones more speedily and reducing waiting times. In response the practice had carried out an audit to identify peak times for telephone calls and had deployed more staff to man the telephones during these times.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they were supported to actively contribute and give their feedback, comments and suggestions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff and those we spoke with said that they would feel confident in reporting any concerns.

Management lead through learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff, all of whom confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and improve patients' experiences and to deliver high quality patient care.

Clinical staff told us that the practice supported them to maintain their professional development through training and mentoring. All the staff we spoke with told us that the practice was very supportive of training and that they had protected time for learning and personal development. Through discussions with staff and a review of records we saw that the practice monitored, reviewed and acted on incidents such as significant events, near misses and complaints to make improvements as needed.