Wivenhoe Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Wivenhoe Surgery on 02 June 2015. Overall the practice is rated as good.

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

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

- Staff understood how to report significant events and to raise concerns. We found that action had been taken in response to safety alerts. Actions were also taken following investigations into significant events, and these were reviewed to evaluate their impact.
- Risks to patients were assessed and well administered, with evidence of action planning and learning when needed addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and the majority said they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The majority of patients said they found it relatively easy to make an appointment with a GP and that there was continuity of care. We were told urgent appointments were available the same day.
- The practice had appropriate facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff told us they felt supported by management.

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on. The practice sought feedback from patients through a patient participation group and a patient survey in relation to the services provided.

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

Importantly the provider should :

- Ensure that staff members who undertake chaperoning have received suitable training and are guided by a clear chaperone policy and procedures in order to minimise risk to both patients and staff during examinations.

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. Lessons were learnt and communicated widely to support improvement although adding incidents as a set agenda item to meetings would reduce the risk of communication to staff being missed. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Safety alerts were correctly managed although evidence that actions had been completed would improve this procedure. Emergency medicines and vaccinations were correctly stored and monitored and the practice was able to respond to medical emergencies safely. Patients had their treatments and medicines reviewed on a regular basis.

There were arrangements to protect patients from the risk of acquiring infections. There were appropriate staff recruitment procedures in place, and an appropriate number of skilled clinical and non-clinical staff employed to deliver the service consistently.

Arrangements were in place to ensure business continuity during periods of fluctuating demand or in the event of an emergency, and staff knew how to access the information to carry out these arrangements.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical audit was used to inform clinical effectiveness, this included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for staff.

Clinical practice, including consent and prescribing, was delivered in accordance with nationally recognised best practice in primary care. Internal clinical learning events were held and clinical effectiveness was discussed amongst staff and managed systematically at

Summary of findings

practice level, evidenced by the meeting agenda's over the past. This system of clinical discussion would be improved by keeping regular recorded minutes from these meetings for clinicians to refer to at a later date.

The practice worked well in partnership with other services to meet the needs of patients. Patients had access to a variety of health promotion information and services that promoted a healthy lifestyle and their health needs were assessed promptly and routinely reviewed.

Are services caring?

Good

The practice is rated as good for providing caring services. The findings from the 2013-2014 GP survey showed that patients rated the practice higher than others in the local area for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We observed staff treated patients with kindness and respect, and maintained confidentiality when greeting them at the practice.

Patients and carers described the service positively. Most told us that they were involved in decisions about their care and treatment.

The practice considered the diverse needs of their patients and action was taken to meet them. Arrangements were in place for chaperones to be available when required. We saw evidence that patients were asked for their consent to care prior to treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a named GP and that there was continuity of care. We were told urgent appointments were available on the same day they were requested. The practice had adequate facilities and was equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff via staff meetings or by internal communication if more urgent.

Representatives from Learning disability places of care that we spoke with prior to the inspection were extremely positive about the practice's ability to meet the needs of the people they cared for.

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Are services well-led?

Good

The practice is rated as good for being well-led. They had a patient charter which gave patients assurance to provide the utmost confidentiality to all patients. There was a clear leadership structure and staff told us they felt supported by management.

The practice had a number of policies and procedures to govern activity we found these were regularly reviewed and up to date. The practice held regular clinical and staff meetings to keep staff up to date. There were systems in place to monitor and improve patient outcomes, service quality, and identify risks. The practice proactively sought feedback from staff and patients, which it acted on. Staff 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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in Depression screening for patients aged over 75 and registered as having Coronary Heart Disease (CHD), Avoiding Unplanned Admissions, and end of life care. Staff were responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The patients had a named GP to provide consistency during their care.

The clinical team met with the local palliative care and hospice teams quarterly to discuss patients on the practice end of life register. Staff had been trained in-house to respond specifically to patient and family needs during these very difficult times. The practice had an identified GP clinical lead for end of life care. There was designated administrative support at the practice to follow-up and liaise with the clinical team for older patient issues, and the practice provided senior health checks to monitor well patients in this population group. Carers were identified and offered appropriate support.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed and reception staff were able to respond to patients requests for these without checking first with the GP. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The recruitment of two new nurses in the last year had enabled greater provision of appointments for patients with long term conditions. The GP and nurse diabetic lead provided a comprehensive treatment facility at the practice including the initiation of insulin for type two diabetics. Carers were identified and offered appropriate support.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice has altered their appointments system in to provide ease of access for families. The GP on duty has the flexibility to see children promptly and the ability to review again on the same day if necessary. High achievement targets for childhood immunisation reflects their values regarding childhood health promotion.

As a small town practice they looked after several members or the entire family and were able to tailor care to family needs. There were four doctors trained in minor surgery and three experienced nurses to facilitate a comprehensive minor injuries service, which supported the practice's relatively rural setting.

The practice works closely with the local maternity services to fully support and work alongside their midwife to provide antenatal and post-natal care. The practice had three female GPs all trained in long acting reversible contraception (LARC) fitting, and two nurses able to deliver basic contraception and sexual health and contraceptive service for young people, including students from the local university.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

The practice offered website bookable appointments in response to patient feedback, and they had increased the number of appointment slots to suit this population group. New patients were provided a health check as were patients over the age of 40, and a similar health check was available to all registered patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including, travellers and those with a learning disability. The practice had committed to a Directed Enhanced Services (DES) in Learning Disabilities, this meant the practice identified and registered patients aged 14 and over because of their learning disabilities and provided 100% of these patients with an annual health check. A DES is a primary medical service other than an essential service that is additional, or out-of-hours. The practice had carried out annual 'Cardiff' health checks for all people with a learning disability on their register. The Cardiff health checks are a comprehensive screening process used to ensure patients with learning disabilities that generally have poorer health than the general population, are regularly monitored. The practice told us they did not rely solely on these checks and saw patients more regularly in response to their needs. The practice offered longer appointments for people with a learning disability. Local providers of learning disability care confirmed to us the practice gave excellent access and flexibility to their learning disability patients. They also told us from the receptionists through to the GPs all staff members displayed a real empathy in regards to their needs.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact to raise concerns. One of the GPs at the practice was the lead within the local CCG for safeguarding, giving them excellent oversight regarding local issues. The practice had a proactive care-advisor who the GPs referred patients to with specific non-clinical needs. The care advisor supported patients from this population group to find alternative non-clinical solutions for their issues and worked closely with the clinical team to feedback on their progress and any developments.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 100% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia through their commitment to the 'Facilitating timely diagnosis and support for people with Dementia' DES.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. They had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice provided an in-house counselling service as well as access to further psychological therapy.

Summary of findings

What people who use the service say

Healthcare professionals told us that the practice helped them to provide good care and were understanding about the needs of patients and the problems that could arise caring for patients. The provider of care gave us positive comments with regards to the access available for their patients to appointments. Staff reported that the reception staff members were very comforting to patients, reassuring them they would be seen very soon.

A representative from a local Pharmacy remarked they had a good level of communication with the staff at the practice, and that any issues were always sorted out quickly although it was quite a big practice.

Prior to our inspection, patients were invited to complete comment cards about their views of the practice. We collected 17 cards that had been left for us and reviewed the comments made. Patients who completed cards were positive about the care they received at the practice. There were 17 cards with comments that were extremely positive about the staff, some referred to both their kindness and helpfulness. Some of those who completed cards reported that they felt they were listened to and involved in decisions about their care. There was one less positive comment that related to the appointment system. Patients reported that they found the practice was clean and tidy.

We spoke with seven patients on the day of our inspection; they told us overall they were happy with the service provided at the practice. Patients told us that they could obtain an emergency appointment, on the same day requested. One patient told us that they could wait a week or more to get a non-urgent appointment, although it was reasonably easy to get a non-urgent appointment.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that staff members who undertake chaperoning have received suitable training and are guided by a clear chaperone policy and procedures in order to minimise risk to both patients and staff during examinations.

Wivenhoe Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Wivenhoe Surgery

Wivenhoe Surgery is a five GP partner practice. Four full-time GP's and one part-time GP serve approximately 8400 people who live in Wivenhoe and Arlesford. The practice holds a primary medical service (PMS) contract to provide their services.

The GPs, two male and three female, were supported by three nurses, three healthcare assistants, a team of 16 administrative assistants, secretaries, reception staff and a practice manager.

The practice is housed in a small building with limited space. There are plans in place for the practice to move to new premises in the imminent future to enable them to further develop the practice and the services it provides. Wivenhoe Surgery also has plans to become a teaching practice in the future after their move.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available from 8.30am to 11.30am every morning and 3.30pm to 5.30pm daily. The practice did not offer extended hours, as a trial period had shown appointments were not used appropriately.

The practice has opted out of providing 'out of hours' services which is now provided by Care UK. Patients can also contact the NHS 111 service to obtain medical advice if necessary.

Before we visited we provided comment cards for patients to complete about their experiences at the practice and reviewed the 17 that had been completed. We also spoke with partner organisations and healthcare professions in the area for their views regarding the practice.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

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

For example:

Before visiting, we reviewed a range of information that we hold about the practice and asked one organisation and two healthcare professionals to share what they knew. We carried out an announced inspection on 02 June 2015. During our visit we spoke with a range of staff these included GPs nurses, the practice manager, receptionist's secretaries and the prescription clerk. We also spoke with patients visiting the practice on the day of inspection that used the service. We observed how people were being cared for and talked with and reviewed the practice policies and procedures. We reviewed comment cards where patients and members of the public had shared their views and experiences of the service, surveys and audits.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Clinical meetings, although not minuted did have agenda's showing clinical topics discussed. These meetings were also used to review safety alerts for example National Patient Safety Alerts (NPSA), and Medicines and Healthcare Regulatory Authority (MHRA) alerts, we were told. The practice manager explained the procedure to deal with alerts at the practice and we were assured that these had been actioned and dealt with appropriately.

Staff we spoke with knew how to report significant events, and we saw records of events that had been reported in the last year. We saw significant events were discussed at staff meetings and staff we spoke with confirmed they were discussed.

The annual review of ten safety incidents showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

We reviewed safety records, and incident reports with root cause analysis (RCA) over the last year. RCA is the recognition and assessment of the reason an incident of an undesirable nature, and the analysis to rectify or prevent future occurrence, showing lessons learned. We tracked ten incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, a nurse had delivered training to staff including a demonstration of the importance of ensuring sharps boxes were sealed before being handed to reception staff members.

Significant events was not a standing item on the practice meeting agenda but we were told if an incident had occurred they reviewed it and talked about the actions taken from both significant/safety events and complaints. There was evidence that the practice had learned from these and that the findings were shared with staff members. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. The practice was open, honest and transparent when mistakes had occurred thus displaying a duty of candour.

National patient safety alerts were disseminated via the practice communication system on the computer to practice staff. Staff we spoke with also told us alerts were discussed at clinical and staff meetings to ensure all staff were aware of any that were relevant to the practice and where needed the action to take. The practice manager had an electronic record of all the alerts that the practice had received and actioned.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding how to share information, properly record documentation of safeguarding concerns and who to contact.

The practice had appointed a dedicated GP as their lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. This GP also provided the local CCG with leadership and education for the North East Essex area. All staff members we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We were told there was practice engagement in local safeguarding procedures and effective working with other relevant organisations these included health visitors, local learning disability care staff, and the local authority.

There was information for patients about requesting a chaperone on a notice in the waiting. (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 chaperone policy had been regularly reviewed and was up to date. The nursing staff, and health care assistants, had been trained to chaperone. Reception staff would act as a chaperone if nursing staff were not available. Not all receptionists had undertaken formal training but they did understand their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Clinical staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice told us that non-clinical staff would no longer be used for chaperone duties until they had undertaken formal chaperone training and the need for criminal records checks had been risk assessed.

Medicines management

We checked medicines and medicine refrigerators and found they were stored securely. There was a policy to ensure medicine was kept at the required temperature, with a description of the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out and stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance and tracked through the practice and kept securely at all times.

We saw audit records and clinical discussion notes that documented the actions taken in response to a review of antibiotic prescribing data. The results showed that prescribing against guidelines had improved by 43.3% reaching 90%.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which requires patients to have regular blood monitoring in accordance with national guidance. We saw that appropriate action had taken based on patients results, and where patients care was shared by the hospital this was recorded and kept up to date on patient's records.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. PGDs are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. We saw the PGDs used by the nursing staff had been reviewed and updated this year.

Cleanliness and infection control

We observed the premises and environment to be clean and tidy although the building presented the practices with challenges to achieving this as it was old. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and were not concerned about cleanliness or infection control but did think the building was old and the décor needed updating.

An infection control policy was available to support staff. This included infection control procedures, the management of needle-stick injuries which was displayed on the treatment room doors and clinical waste management. The policy gave guidance to staff regarding, personal protective equipment, disposable gloves, aprons and coverings that we saw were available for staff to use.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out an audit and identified areas of non-compliance. The practice mitigated the risks identified by regular monitoring. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and paper hand towel were available in treatment rooms.

The practice had undertaken risk assessment of legionella contamination in accordance with national guidelines. This was confirmed in the recent clinical audit. Legionella is a

bacterium which can contaminate water systems in buildings. The practice carried out regular checks in line with their infection control policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient and adequate equipment to enable them to carry out diagnostic examinations, assessments and treatments. Records showed that there were effective arrangements in place to check, service and recalibrate all clinical equipment, supported by an up to date protocol. For example, emergency and blood testing equipment were checked monthly. Medical screening equipment was recalibrated in accordance with manufacturers' instructions, and records supported these arrangements, such as portable appliance testing and showed equipment was suitable for use.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at five staff files and they contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice manager provided us with evidence about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were shown the way the practice measured demand to ensure that enough staff members were on duty. The staff told us there was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy with health and safety information that was displayed for staff to see, and there was an identified health and safety representative.

When identified risks were added to a risk log and each risk was assessed and actions recorded to reduce and manage it.

There were monitoring systems in place for patients with long-term conditions. Staff told us referrals were made for patients whose health had deteriorated suddenly and explained how a summary of their care was sent with the patient to ensure healthcare professionals had current and up to date information to treat them.

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 equipment was available including access to oxygen and an automated external defibrillator (AED, used in cardiac emergencies). An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm. AEDs are used to treat sudden cardiac arrest (SCA). SCA is a condition in which the heart suddenly and unexpectedly stops beating. When we asked members of staff, they all knew the location of this emergency equipment and records confirmed that it was checked regularly. We found that the pads for the automated external defibrillator were within their expiry date and suitable for use.

Emergency medicines were accessible to staff in a safe area of the practice and all staff knew the location. These included medicine for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Anaphylaxis is a sudden allergic reaction and hypoglycaemia, or low blood sugar, is a common problem in people with diabetes. Processes were also in place to check whether emergency medicines were within their expiry dates and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was available to staff and last reviewed in 2015.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff had attended fire training and that they had practised fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw how they accessed these from icons on their computers.

We were told and saw the agenda items for clinical meetings where clinical updates were discussed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff explained how care was planned to meet identified needs and how patients were reviewed six monthly to ensure their treatment remained effective. For example, patients with diabetes had regular health checks and were being referred to other services when required.

The GPs told us they lead in specialist clinical areas such as diabetes, dermatology, minor surgery and child protection, and the practice nurses supported this work. Clinical staff we spoke with told us they cross referred to use their specialist knowledge and were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital as part of the admission avoidance work they were involved with. This work included developing a written and electronic personalised care plan collaboratively, with the patient and their carer (if applicable).The care plan was jointly owned by the patient, carer (if applicable) and named accountable GP. These patients were reviewed regularly to ensure the multidisciplinary care plans were documented in their records and their needs were being met, to assist in reducing the need for them to go into hospital. We were told when high risk patients were discharged from hospital they were followed up to ensure their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. We were told 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. This formed part of the statement of purpose for the practice.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical and administrative audits.

The practice showed us two clinical audits that had been undertaken in the last year. Both of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example all clinicians at the practice changed their treatment approach for tonsillitis to follow gold standard guidance. When they reviewed patient outcomes after the initial audit they concluded a consistent practice wide approach following guidelines improved patient outcomes and reduced the amount of antibiotic use for patients.

The GPs told us clinical audits were often linked to the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98.1% of the total QOF target in 2014, which was 4% above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average.

Good

Are services effective?

(for example, treatment is effective)

The clinical staff we spoke with told us how in the weekly clinical meetings they discussed and reflected on the outcomes being achieved and areas where this could be improved. Staff members; spoke positively about the practice approach to audit and quality improvement.

The practice's prescribing rates were also similar to national figures. There was a policy for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had a palliative care register and had regular internal and multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example travellers, and learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example diabetes, chronic obstructive pulmonary disease (COPD), and heart failure.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff members had attended role related training courses and all staff had attended annual basic life support.

We noted there was a good skill mix among the doctors in clinical areas such as diabetes, dermatology, minor surgery and child protection. All GPs were up to date with their yearly continuing professional development requirements or had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example first aid training, smart card training, and health and safety.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology infection control and dressings update.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a procedure outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues that arose in these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GPs who saw these documents and results was responsible for the action required. Staff we spoke with identified the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were similar to expected at 1.391% compared to the national average of 1.36%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We were told about the procedure used to action hospital communications to ensure that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs. For example, those with multiple long term conditions, learning disciplinary problems, and those with end of life

care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. Information from the out-of-hours service provider was checked on a daily basis by the secretaries and flagged to the relevant GP for them to action.

For patients who were referred to hospital in an emergency there was a procedure to provide a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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 which enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The staff told us they would free text into the patient's record that the patient was Gillick competent.

There was a practice policy for 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 discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and staff were clear about when to obtain written consent.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by public health and the Clinical Commissioning Group (CCG) to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

The practice offered a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic life style advice and smoking cessation advice to smokers.

The practice had many ways of identifying patients who needed additional support, and was pro-active in offering additional help. For example, the practice had identified the smoking status of patients over the age of 16 and

Good

Are services effective?

(for example, treatment is effective)

actively offered nurse-led smoking cessation clinics to these patients. The practice's performance for smoking cessation was 98%, which was 4.3% above the national average of 93.7%. Similar mechanisms of identifying 'at risk' groups were used for patients who needed dietary advice and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 95.1%, which was 2.4% below the national average of 97.5%. Follow up of cervical screening is undertaken by Anglian Community Enterprise (ACE) to ensure patients are provided this screening if they did not, or could not, attend their appointment at the practice. ACE is a local healthcare provider that delivers community care in the North East Essex area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice nurse telephones those patients that did not attend their vaccination appointment to ensure courses of treatment are completed and they are not missed. Last year's performance was similar to expected for the majority of immunisations where comparative data was available.

Patients had access to a range of information to support them to achieve and maintain healthy lifestyles. Written information was available at the practice, and on the practice website about common medical conditions, support agencies, immunisations and other health promotion issues. Posters displayed within the waiting area informed patients of the range of health and social care services available that may meet their current needs. Further health promotion information was included in the practice leaflet.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw patients were treated with dignity and respect by staff when being greeted by reception staff and in answering patient enquiries. Privacy was maintained due to the reception being separate from the waiting room for patients to speak with a receptionist and book appointments. There was also information available in the patient's waiting room telling patients they could request to speak with staff in private. We saw how staff observed patient confidentiality discussing matters quietly and sensitively to mitigate the risk of being overheard. Staff checked patients' identity by using their dates of birth rather than their name. A touch screen facility was available for patients to check-in for their appointments without the need to discuss health concerns at the reception desk.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published on 8 January 2015, 260 survey forms were distributed for this practice and 138 forms were returned providing a response rate of 53.1%.

Before our inspection we left comment cards for patients to complete to give their views on the practice. We received 17 completed comment cards. There were 16 very positive cards revealing information about their excellent treatment by staff and describing staff as friendly, respectful and helpful. One card was less positive, the patient commented on a long wait for an appointment.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey 2015 showed:

- 90.4% of patients found it easy to get through to this surgery by phone compared to the CCG average of 70% and national average of 71.8%
- 90.8% of patients found receptionists at the surgery helpful compared to the CCG average of 86.5% and national average of 86.9%
- 92.3% of patients had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 88.5% and national average of 85.5%

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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.

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. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

A healthcare professional involved with the care of vulnerable adults told us the reception staff members were particularly comforting to the patients they brought to the practice, and reassured them if they were anxious.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed published on 8 January 2015 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice similar to other practices in these areas. For example:

- 78% of patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 82.0%.
- 61.8% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 68.5% and national average of 66.2%.

Patients we spoke with on the day of our inspection 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 and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed published on 8 January 2015 showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 77.5% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81.5% and national average of 82.7%.
- 83.5% s of patients who responded aid the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81.3% and national average of 78.0%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, in the practice leaflet and the patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice identified patients who may be acting as informal carers for patients. Carers were invited to identify themselves and this was recorded on their own record and that of the person they cared for. Carers were provided a pack of information that signposted them to support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The practice manager shared with us the evaluation of the practice needs to ensure there was sufficient staff numbers and the correct skill mix to keep patients safe.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

The practice had an action plan on the day of inspection to implement improvements, and made changes to the way the appointment system was delivered in response to an internal appointment survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the opportunity for longer and flexible appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets. There was sufficient space within the waiting room for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice told us they would register patients as temporary residents if necessary to ensure they could access medical services for example where a person may have no fixed abode.

There were male and female GPs in the practice providing patients with choice.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments are available from 8.30am to 11.30am every morning and 3.30pm to 5.30pm daily.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments and order repeat prescriptions through the website. 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.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

The patient survey information we reviewed published on 8 January 2015 showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 73.4% of patients who responded were satisfied with the practice's opening hours compared to the CCG average of 74.2% and national average of 75.7%.
- 79.2% of patients who responded described their experience of making an appointment as good compared to the CCG average of 73.2% and national average of 73.8%.
- 71.8% of patients who responded said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 60.6% and national average of 65.2%.
- 90.4% of patients who responded said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 71.8%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were satisfied with the appointments system and said they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, posters were displayed in the waiting room, there was information on the practice leaflet, and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at nine complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and noted there were no themes identified. However, lessons learned from individual complaints had been acted on and improvements made as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included: providing the best possible quality service for our patients. To be courteous and respectful at all times irrespective of ethnic origin, religious belief, personal attributes or the nature of the health problem. To involve our patients in decisions regarding their treatment and promote good health and well-being to our patients. Also to ensure that all members of the team have the right skills and training to carry out their duties competently.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of computers within the practice. We looked at 15 of these policies and procedures and all those we looked at had been reviewed annually and were up to date.

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 a GP lead for safeguarding. We spoke with members of staff and found they understood 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 GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example diabetes patients, and adherence to guidance when treating tonsillitis. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held quarterly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, and management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and given the opportunity to express ideas regarding how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We were shown agenda's for clinical team meetings held weekly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at full staff team meetings quarterly, were confident in doing so and felt supported if they did. Staff told us they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the friends and family test the annual practice GP survey and ad hoc surveys to understand specific aspects of practice service delivery. We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training and had recently registered for e-learning to support their role development.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. We saw the most recent analysis improved both staff and patient safety.