The Practice Osler House

Quality Report

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Date of inspection visit: 01 October 2014
Date of publication: 22/01/2015

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

Overall we found the practice provided patients a good service with two areas that required some improvement. The areas where improvement was needed were; there was scope to better embed learning from incidents through more formal dissemination of information to staff and improved recording of this learning. There was also scope to formally document staff meetings in order to provide formal records of internal communication within the practice.

Our key findings were as follows:

- Patients were pleased with the improvements to the service provision over the previous 18 months.
- The Practice had worked with local care homes, healthcare professionals and schools to improve communication around patients' health needs?

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

The provider should:

- Ensure that learning from incidents and complaints is formally disseminated to all staff and that this learning is formally documented.
- Formal notes should be taken during staff meetings to provide a record of internal communication.

Professor Steve Field CBE FRCP FFPH FRCGP

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 service at the practice is safe with areas where the practice should make improvements. Policies and procedures were available for reporting accidents and incidents and responding to complaints.

We saw that there were no complaints raised regarding patient safety and the comment cards we had left for patients to complete raised no issues regarding safety with patient care. The practice had a system to record, and investigate adverse incidents.

The practice had appointed a GP as the safeguarding lead for adults and children. The practice had suitable procedures for protecting patients against the risks of infections. The emergency equipment was checked regularly, and was appropriate for emergency use.

Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits.

The practice had clear procedures in place for dealing with emergency situations or events that may disrupt the delivery of service or impact upon the care and treatments provided to patients. There was a business continuity plan in place for staff to refer to in the event of disruption to the service.

There were arrangements in place for dealing with medical emergencies. Staff had undertaken training in basic first aid, cardio-pulmonary resuscitation (CPR) and treating anaphylaxis (potentially dangerous allergic reactions to medicines and vaccines). Staff were aware of the procedures to follow in the event of a medical emergency.

Are services effective?

Good

The practice is rated as good for providing effective services. We found the clinicians followed NICE guidelines and there was a process for disseminating the information on the computer system used by the clinicians. We saw that secondary care referrals were made appropriately and in a timely way to ensure the best outcomes for patients.

Training and development assessments were made during staff performance plan reviews. The Nurse had been mentored and received regular clinical supervision, support and advice from the lead GP when needed.

Summary of findings

Staff from a local care home reported that the doctor was proactive in reviewing and treating patients. They also reported a good level of communication with the practice manager who visited personally to talk with them if there was an issue.

There were arrangements for monitoring the health and reviewing treatments for patients with chronic or long term conditions. We found that all new patients were invited to attend a new patient check where a brief medical history was obtained and additional health services offered.

Staff demonstrated they were aware of the Mental Capacity Act (MCA) and how it may relate to the patients they treated.

Are services caring?

Good

The practice is rated as good for providing caring services. We asked what training and support staff were given to meet patient's individual needs and ensure they were treated with respect and compassion. Some staff had undertaken patient care training and this included how to communicate with patients experiencing reduced circumstances. We saw staff were required to undertake equality and diversity training. We looked at staff personnel records that confirmed staff had received this training.

When patients registered at the practice they were invited to disclose their preferences for the practice to provide individualised care. Where patients lacked capacity to make decisions or required additional support to make decisions clinical staff acted in accordance with the mental capacity act. Staff demonstrated that they were aware of the Mental Capacity Act (MCA) and how it may relate to patients.

Where family, friends and advocates were involved in the care of patients registered at the practice this was recorded on their medical records and disclosures were made in accordance with the patient's wishes.

Are services responsive to people's needs?

Good

Services at the practice are responsive to people's needs. Practice staff were able to demonstrate that they had responded to the concerns of patients. For example, the practice had changed their appointment system in response to patient concerns raised through their patient participation group PPG. A

PRG is a patient and staff group who meet to discuss ways in which the service could be improved for patients. We saw several audit cycles used to improve the notes taken on patients medical records at the practice.

Summary of findings

The practice held a register of vulnerable patients to ensure That patients' changing needs were met. They also regularly reviewed the care provided to patients living in residential care.

Due to the nature of the building there was access for patients with reduced mobility and there were disabled parking facilities. Home visits were available for patients who were frail or too unwell to attend the practice.

The practice leaflet explains how the practice dealt with complains concerns and comments, and a poster in reception signposted the local 'Making Experiences Count Team' and a contact number. The 'Making Experiences Count Team' record patient's compliments, as well as complaints, to help improve services for everyone. The team investigate complaints to ensure that the services provided are constantly improved for the North Essex Partnership Trust.

We saw complaints were responded to appropriately, apologises were given where appropriate and investigated in a timely way.

Are services well-led?

Good

Services at the practice are well-led. The practice had a vision statement within their practice leaflet – 'Patients come first'. This outlined their aim to deliver genuinely caring and patient-centred services. We also saw the practice statement of purpose that listed their aims and objectives for the service.

Governance arrangements were overseen by the primary care company that owned the practice; this included the systems that governed serious incidents, complaints and practice risks. We saw the practice had achieved an overall rating of level two for information governance using the 'information governance (IG) toolkit'. This implied that data quality was maintained to a satisfactory standard.

The practice had an active and well represented patient participation group (PPG). We were told they met monthly with the practice and that some weekly or daily conversations took place.

Staff were updated on the outcome of patient surveys and actively engaged in the redefining of the appointment system in response to patient concerns.

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 had systems in place to identify people aged over 75; each person had a named accountable GP in line with the recent GP 2014 to 2015 contract changes.

We found the practice provided care to meet older people's individual needs. They accomplished this by surveying and, talking with patients to understand their needs and support their choices. The practice identified patients with caring responsibilities or those that needed additional support; this was recorded in their records. By identifying those with caring responsibilities this enabled staff to consider these responsibilities when discussing care and arranging appointments to ensure they were suitable for patients.

The practice showed us they had a good uptake of flu vaccinations for patients 75 years and over. They had also encouraged the uptake for shingles vaccination; at least half the patients eligible for treatment had already received it.

We found that although staff had not received detailed training to understand the needs of older people, we saw that staff were polite, patient and helpful with older people whilst trying to book appointments and assist them with their enquiries. Staff told us they recognised patient's individual needs such as limited mobility or difficulties reading or writing and tried to support them.

Practice staff told us they monitored emergency admissions to hospital and reviewed all unplanned admissions or readmissions for patients over 75years of age. These reviews involved a medication review within 72 hours of their discharge from hospital to ensure that patients were not readmitted to hospital where this was avoidable and appropriate.

People with long term conditions

Good

The practice identified those people with long term conditions at the practice with a long term conditions and placed them on a clinical register to oversee and maintain their care. Where appropriate, patients had been appointed a clinical lead to co-ordinate and oversee their care, this included assistance and support to self-manage their conditions. We found patients had been advised with regards to specialist services they could access to meet their individual needs and had been signposted to additional support networks to assist them.

We found records of regular multidisciplinary meetings, these were held monthly and detailed discussions, and any actions that were assigned to staff members were then reviewed at subsequent meetings. These discussions included reviewing all unplanned admissions or readmissions of patients with long-term
conditions.

Summary of findings

We found regular patient care reviews were conducted by the GP and the nursing team for those patients identified with a long term condition. These were in consultation with patients and carers where appropriate to ensure the information was accurate and they were involved in their care. We found patients had been referred appropriately to specialists and in an appropriate and timely way.

Families, children and young people

Good

We looked at arrangements the practice had in place for families, children and young people. We saw that consideration had been given to the appointment system and availability for children outside the school open hours to ensure their access to health provision. This availability was managed by offering early opening at 8:00am four days a week and one morning at 7:30am and extended evening opening hours on two days a week until 7.30pm one evening and 8:00pm on another.

The practice accommodated the midwifery service every Monday morning to provide local antenatal care. This meant only those mothers at the practice that needed consultant led antenatal care needed to attend the hospital to meet their antenatal needs. Expectant mothers' needs were assessed individually and their care plans reflected this, for example, receiving general information on healthy lifestyle choices and how to access community services and support networks.

The practice told us there was a good up-take rate for pregnant mothers receiving the flu vaccine this year.

We found that clinical and administrative staff had received safeguarding training to recognise and respond to safeguarding concerns. We saw there was a system in place for the timely identification and management of children where safeguarding concerns within a family were identified.

The practice had five children with complex health needs; these children required a multidisciplinary approach to the management of their health conditions. Staff told us how they had detailed care plans in place and the practice supported their carer's.

The practice conducted regular assessments of children's development and monitored the up-take of primary and pre-school immunisation to identify children at potential risk. Where concerns were identified with regard to physical and/or mental health of a child, appropriate and timely referrals to partner agencies were made and documented.

The practice told us they had attended meetings with the local primary school and nurseries to discuss ways they could help to support children's health in the community.

Summary of findings

Working age people (including those recently retired and students)

Good

We asked staff how they made sure the appointment system was accessible for working age people to attend and contact the practice. We were told the practice offered extended opening hours, telephone consultations; ring backs, and priority appointments. The practice had also introduced online booking and a text reminder system for those patients who had signed up for it. The practice opened at 8:00am four days a week and one morning at 7:30am and extended evening opening hours on two days a week until 7.30pm one evening and 8:00pm on another.

The practice had monitored their accident and emergency (A&E) admissions and identified that there was no increased correlation between working people attending A&E outside normal practice hours registered at the practice.

When patients required referral to specialist services they were offered a choice of services, locations and dates. Patients were also informed by staff of pharmacy opening times ahead of bank holidays so patients could obtain their medicines.

The practice provided screening clinics and signposting for this population group. These included family planning, contraception and follow-up, cervical smears, health advice regarding lifestyle, diet, smoking and alcohol intake, new patient health checks and chlamydia screening.

People whose circumstances may make them vulnerable

Good

We were told that staff had received training in identifying vulnerable adults and children. They currently had no patients on treatment programmes for addictions at the practice. However, where appropriate patients were encouraged to attend regular health screenings including HIV testing and to participate in vaccination programmes.

Staff told us about the care they provided care for patients who had been identified as vulnerable due to their diagnosis of a learning disability. The practice worked closely with local services for example adult social care, community health services, and financial support services to access specialist equipment and to promote patients independence. The practice also works with the department of work and pensions to provide evidence to support claims, and continuity of care to enable patient's access to services. They conducted annual health checks to ensure that patients' needs were identified and that they could access the care they required.

The practice showed us how they monitored the needs of their vulnerable patients via their risk register. They explained they had responsive support care plans in place to ensure patients felt able to access timely and appropriate care. They also identified alerts from the Clinical Commissioning Groups regarding patients who potentially abuse substances or were missing locally.

Summary of findings

We asked staff what training and support they were given to enable them to recognise and respond appropriately to vulnerable patients. Staff said they felt comfortable supporting patients who may experience difficulty communicating, have mobility issues or present differently from others due to their lifestyle choices.

The practice told us they had a register of patients who may be considered vulnerable due to a number of factors including deprivation and rural isolation The practice had no known patients who had no fixed abode or who were nomadic. W here concerns had been raised regarding the living standards of a person the practice had worked with the person and social care to access the care and support they needed.

We spoke with a local care home that provided care to patients with learning disabilities and dementia. They told us the practice always treated the patients they bought to the practice well and with respect and dignity. They spoke to each person before the carer and explained treatment. The home told us the staff were very helpful and were responsive to the needs of the patient at the home. No problems had been experienced by the home with regards to the practice provision of prescriptions, secondary care referrals, or test results. We were also told the practice manager came to meet with the home manager regularly to maintain good level of communication.

People experiencing poor mental health (including people with dementia)

Good

We asked the practice how they met the needs of people experiencing poor mental health. They told us there was an appointed lead clinician responsible to oversee the care provided to people experiencing poor mental health. The clinical staff told us about wider community health services that patients can access and showed us their care pathways to access mental health services for children and adolescents.

In addition, we found the practice monitored the mental health needs of patients to ensure they could access services and were supported throughout their care.

We asked staff what training and support they were given to enable them to recognise and respond appropriately to patients experiencing mental illness. Staff had received no specific training but the practice manager explained that the staff knew patients well and were sensitive in addressing patient's individual needs. Staff had also been taught to recognise and escalate health concerns to the clinical team by the appointed lead clinician responsible for this population group at the practice.

The practice monitored the A&E admissions of patients experiencing poor mental health or had attended due to self-harm. The practice told us they were not currently involved in any mental health assessments, guardianship orders, or deprivation of liberty orders.

Summary of findings

The practice monitored their prescribing of anti-psychotic medication and this was seen to be low.

Other universal support services such as advice and counselling services were available to patients via community services such as Mind (a mental health charity).

Summary of findings

What people who use the service say

We spoke with three people on the day of our inspection and reviewed two comment cards completed by people who attended the practice ahead of our visit. Both the people we spoke with and the comments on the cards were extremely positive. People told us that the staff were polite and helpful and the practice was safe clean and tidy.

We received feedback from a representative of the practice patient's participation group (PRG). A PRG is a patient and staff group who meet to discuss ways in which the service could be improved for patients. The PGG representative told us the group were very pleased with the improvements that had taken place over the last year at the practice.

One person we spoke with told us they had experienced problems in the past at the practice, with insufficient information recorded on their records. We were told by the person that it was no longer an issue. People told us they now had confidence with the clinicians at the practice, and that their information was recorded correctly and confidentially.

The people we spoke with told us that they could easily access appointments at times to suit them.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that learning from incidents and complaints is embedded through a formally recorded process which is disseminated to all staff.
- Formal notes should be taken during staff meetings to ensure documented lines of internal communication.

The Practice Osler House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a lead CQC inspector and a GP. The team included a second CQC inspector and a second GP.

Background to The Practice Osler House

The Practice Osler House is located; Potter Street, Harlow, Essex, CM17 9BG. The practice provides a range of primary medical services to around 3140 patients.

The practice is managed and owned by a primary care company. The company holds a PMS contract to provide their services. The company employs one full-time male salaried GP and regular part-time locum GPs. The GPs at the practice are supported by a practice manager, a practice nurse prescriber, a healthcare assistant, and a team of reception and clerical staff.

The practice has opted out of providing out-of-hours services to patients. These services are provided by a local out-of hour's provider and details of how to access these services are available in the practice, in the practice leaflet, and on their website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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..

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 held about the practice and asked homes and healthcare

Detailed findings

professionals that were involved with and worked at the practice, to share their views of the service provided by the practice. In addition we reviewed information we requested after the inspection visit.

Are services safe?

Our findings

Safe Track Record

Policies and procedures were available for reporting accidents and incidents and responding to complaints.

These were in line with national and statutory guidance, for example, from the Health and Safety Executive. Staff we spoke with knew how to report incidents and who to approach at the practice for advice or support.

The practice had a system for dealing with the alerts received from the Medicines and Healthcare products

Regulatory Agency (MHRA) and National Patient Safety Alerts (NPSA). The alerts had safety and risk information regarding medication equipment and procedures, this can result in the withdrawal of a medicine from use and return to the manufacturer. We saw that all the alerts received by the practice had been allocated to staff members to action, and these had been completed.

During our inspection we spoke with five patients who gave us positive comments about the care they received at the practice. The staff members at the home looking after people with learning disabilities and dementia, told us people received safe care and treatment that was always explained to them when they attended the practice. We saw that there were no complaints raised regarding patient safety and the comment cards we had left for patients to complete raised no issues regarding safety with patient care.

Learning and improvement from safety incidents

The practice had a system to record, and investigate adverse incidents. We saw the incidents policy, and the actions taken for each incident followed a root cause analysis process (RCA). RCA is a method of problem solving that tries to identify the root causes of faults or problems. The practice had a good recording system and we could see the learning points and changes to procedure, where needed, or identified. Any change to practice procedure following an incident and investigation though was shared with staff at the practice in regular meetings verbally we were told. Notes were not taken during these meetings which meant the practice could not evidence this had occurred. Learning and communication of these incidents was also not recorded on the system or the spread sheet we were shown.

Reliable safety systems and processes including safeguarding

The practice had appointed a GP as the safeguarding lead and had completed appropriate safeguarding training to level 3. The lead role included promoting staff awareness of safeguarding and communication with other healthcare professionals who linked with the practice regarding these issues. Where there were safeguarding concerns with patients registered at the practice, these were identified on the patient computer records system to ensure staff were alerted. Staff told us if they had any safeguarding concerns, they would speak to the safeguarding lead at the practice. The practice had up-to-date guidance, contact details and referral information for the local social services safeguarding team that was used for safeguarding referrals.

The practice told us they monitored the emergency admissions made to local hospitals and reviewed all unplanned admissions or readmissions for patients over 75years of age. These reviews involved a medication review within 72 hours of their discharge from hospital to support hospital admission avoidance work with this population group. The practice had monitored their accident and emergency (A&E) admissions and identified that there was no increased correlation between working patients attending A&E outside normal practice hours registered at the practice. In addition, we found the practice monitored the mental health needs of patients to ensure they could access services and were supported throughout their care.

We saw there was a chaperone facility available to patients attending the practice. A chaperone is a person who is present as well as the person who is examining you. All patients (male and female) are entitled to have a chaperone present when an intimate examination or procedure will take place. There were notices displayed throughout the practice to make patients aware of the chaperone facility for patients' use. A member of staff told us that a chaperone did not have to be pre-arranged before an appointment and the practice could accommodate patients' requests. We were told the nurse/healthcare assistant at the practice was used to chaperone if one was requested. Clinicians told us they offered the service before a physical or intimate examination.

Are services safe?

Medicines Management

The practice had suitable arrangements for secure storage of medicines, this including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure they remained effective.

Information for patients around repeat prescriptions was clearly stated in the patient information leaflet which was available in the reception and waiting room and re-enforced with notices in the reception and waiting room. There was also guidance on the practice website that repeat prescription requests could be made online, by post, or by request in person at the practice. Repeat prescriptions were provided on a 28 day cycle in line with the practice policy and national guidelines around medicines prescribing and repeat prescriptions. Arrangements could be made for alternative cycles if circumstances arose that required a different time period. Patients were reminded to make an appointment when requested, by the practice, for a medication review.

The local care home that we spoke with told us they had experienced no problems with prescriptions received from the practice due to good communications with the practice manager.

We checked the emergency medicines and anaphylaxis treatment (anaphylaxis is the most serious type of allergic reaction). The emergency medicines had been regularly checked. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date and suitable for use.

People we spoke with told us they were given information such as side-effects and any contra-indications about the medicines they were prescribed. They told us that the repeat prescription service worked well and they received their medicines in good time. They also confirmed that their prescriptions were reviewed and any changes were explained fully.

Cleanliness & Infection Control

The practice had suitable procedures for protecting patients against the risks of infections. There were infection control policies and procedures available for staff to follow. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments, and needles and dealing with needle stick injuries.

All areas of the practice, including consultation and treatment rooms were visibly clean and tidy on the day of inspection. We saw there were signs showing effective hand washing techniques displayed next to the hand washing facilities, and hand sanitising gels were available for use

We received comments from patients and healthcare professionals visiting the practice who told us they thought the practice was always clean and tidy when they attended.

The practice had appointed an infection control lead who understood their role and responsibilities. The 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.

There were arrangements in place for the storage and disposal of waste matter including clinical waste.

The practice employed an external cleaning contractor to carry out general cleaning tasks. Their contract required them to undertake environmental infection control checks and audits against the cleaning checklists. The practice manager checked the contractor's checks to audit the contract they held with the cleaning contractor.

Equipment

We checked the equipment used by the practice to monitor patients with chronic disease and saw that, where required, this had been annually checked in line with the manufacturer's guidelines. The emergency equipment was checked regularly, and was appropriate for emergency use. The oxygen at the practice was in date and appropriate for use.

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. Employment references and criminal records checks were obtained for all newly appointed staff before they started work at the practice. There were procedures in place for managing under-performance or any other disciplinary issues.

Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed if required

to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures), or adverse weather conditions.

Monitoring Safety & Responding to Risk

The practice had a staff rota that set minimum staffing levels and these were reviewed. Patients we spoke with and those who completed comment cards said that they could access appointments to meet their needs. There were arrangements for increasing staffing levels to manage increased demand for services as part of the business continuity plan.

The practice conducted regular assessments of children's development and monitored the up-take of primary and pre-school immunisation to identify children at potential risk. Where concerns were identified with regard to physical and/or mental health of a child, appropriate and timely referrals to partner agencies were made and documented.

Arrangements to deal with emergencies and major incidents

The practice had clear procedures in place for dealing with emergency situations or events that may disrupt the delivery of service or impact upon the care and treatments provided to patients. The practice business continuity plan gave staff the information needed to deal with emergencies and major incidents. Staff members told us all policies and procedures could be accessed in hard copy within the practice and on the computers that they could all access.

The practice had clear procedures in place for dealing with emergency situations or events that may disrupt the delivery of service or impact upon the care and treatments provided to patients. There was a business continuity plan in place for staff to refer to in the event of disruption to the service. The plan included instructions on what to do if there was a failure in the supply of domestic utility services, a fire or a change in staffing numbers. The plan contained the emergency contact numbers that would be needed if emergency procedures had to be implemented. This ensured that some or all of the service could be maintained if an emergency or major incident occurred. Staff were aware of the arrangements at the practice for identifying and responding to emergency situations.

There were arrangements in place for dealing with medical emergencies. Staff had undertaken training in basic first aid, cardio-pulmonary resuscitation (CPR) and treating anaphylaxis (potentially dangerous allergic reactions to medicines and vaccines). Staff were aware of the procedures to follow in the event of a medical emergency. They could describe how they would summon assistance in the event of urgent or emergency situations such as physical health emergencies, mental health crises, or other incidents. The practice had suitable equipment and medicines to deal with medical emergencies. These were checked by the practice staff to ensure that they were in date, we found these fit for use if they were required.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found that clinicians followed NICE guidelines and there was a process for disseminating the information on the computer system used by the clinicians. NICE guidelines provide national guidance to health and social care providers to improve health and social care. It develops standards and information on high quality health and social care. The practice met their two week wait commitments for cancer referrals, and followed prescribing and medicines management advice shown by the actions taken in line with local medicines management initiatives to improve prescribing outcomes. During our conversation with the doctor we were able to ascertain that care and treatment was delivered in line with recognised best practice standards and evidence based guidelines.

There were procedures and clinics in place in order to monitor the needs of patients with chronic long term conditions such as diabetes, heart disease and chronic obstructive pulmonary disease (COPD). These ensured patients were reviewed, monitored, and their quality of life maintained. Monthly multi-disciplinary meetings were held with district and community nurses to ensure that services were planned and co-ordinated to meet the changing needs of patients. Up to date information was available via the computerised patient records system so that all agencies involved in the treatment of patients including the 'out of hours' services were aware of patient's needs.

Management, monitoring and improving outcomes for people

We saw that secondary care referral rates demonstrated timely and appropriate referrals made for patients. Patients were referred for the correct treatment to meet their needs. Prescribing practices had significantly improved over the last 18 months and this was demonstrated through the quantitative data we were shown.

The lead doctor was not currently able to conduct clinical audits as they had not been given access to protected time to do so. However within the lead doctors personal development plan there is a need to produce an audit for minor operations

We saw several audit cycles used to improve the notes taken in patients' medical records at the practice. Patients that we spoke with told us that they had experienced problems in the past at the practice, with insufficient information recorded on their records. We asked several people if they had experienced this problem. We were assured by each person we spoke with that it was no longer an issue and they had confidence with the clinicians at the practice, and that their information was recorded correctly and confidentially.

Effective staffing

We found that the primary care company that owned the practice provided a consistent staff induction programme for staff employed in their practices. However staff did report that mandatory training was overdue but had been scheduled.

Training and development assessments were made during staff performance plan reviews. The GP had mentored and given regular clinical supervision, support and advice to the nursing staff when needed. This had led to them gaining extra skills to benefit patients at the practice.

Working with colleagues and other services

The doctor took responsibility for managing and viewing blood results daily. We saw the information was recorded onto patients' notes promptly.

The practice did not provide an out of hours (OOH) service for its patients. This is contracted out to another provider. There were arrangements in place to inform the local out of hour's service about any patients on a palliative care pathway. Information about patients currently receiving palliative care and those with chronic long-term conditions was available on the computerised system medical record. Therefore, if patients contacted the OOH service, appropriate information was available to enable suitable treatment. There was a robust system for ensuring patients' information and their needs were shared in a timely manner between all of the organisations involved in patient's care and treatment. There were arrangements in place to work with the local out-of-hours service to ensure that information about treatment and any risks were handled appropriately.

The GP and the nurse at the practice attended a monthly multi-disciplinary care meeting with other healthcare professionals, organisations and social services to ensure that care and support was delivered in a co-ordinated way for patients that met their changing needs.

Are services effective?

(for example, treatment is effective)

Staff from a local care home reported that the doctor was proactive in reviewing and treating patients. They also reported a good level of communication with the practice manager who visited personally to talk with them if there was an issue.

The doctor told us they followed the clinical commissioning group initiative of locally integrated agreed referral care pathways, and promoted co-ordinated care through attendance of a monthly multidisciplinary team meeting.

Information Sharing

There was evidence that the practice identified and recorded whether patients were also carers. During new patient checks clinicians recorded the treatment and information patients were comfortable releasing. This ensured patients received the care and treatment in the way they wanted.

Information regarding the immunisations received at the practice was shared with the vaccination programmes to ensure that patients' status and entitlement were recorded. Vaccination history status is often required by patients before travel, before being accepted into work or education.

We found that there was information provided to patients at registration on the NHS Care Data programme. This related to the sharing of health information with other healthcare providers, with the aim of improving patient outcomes. We saw that the practice had provided a clear explanation and shown that patients could make a choice about agreeing to this proposal.

Consent to care and treatment

We looked at the procedure in place for obtaining patient consent prior to receiving minor surgery. We found consent forms were completed appropriately and included an explanation of the benefits and potential risks of procedures. Patients had signed and dated their consent forms and agreed to the procedure being undertaken.

Staff demonstrated that they were aware of the Mental Capacity Act (MCA) and how it may relate to the patients they treated. The Mental Capacity Act (MCA) (2005) is designed to protect people who may require support to make decisions which are in their best interest.

A member of staff at a local care home told us that they valued the way staff at the practice related with the patients they cared for. They found both administrative and clinical staff responsive and supportive in meeting their residents' needs in a timely and professional manner.

Staff at the practice told us they checked with those patients that attended with a carer whether they wanted the carer to remain in the consultation room with them.

Health Promotion & Prevention

We found that all new patients registered at the practice were invited to attend a new patient check where a brief medical history was obtained and additional health services offered. The checks were conducted by the practice nurse and patients were referred to the doctor when appropriate such as a repeat medication review.

There was a range of health promotion leaflets available in the waiting area with information to promote physical and mental health and lifestyle choices. We saw information about mental health and domestic violence advice and support displayed in waiting area with helpline numbers and service details. Information available included advice on diet, smoking cessation, alcohol consumption and contraception. Sexual health and smoking cessation sessions were provided. There were also leaflets signposting patients to other local and national support and advice agencies.

There were arrangements for monitoring the health and reviewing treatments for patients with chronic or long term conditions such as such as diabetes, heart disease, respiratory problems, dementia and stroke. The practice held weekly clinics for patients with a range of chronic or long term health conditions such as diabetes, asthma and chronic obstructive airways disease (COPD). The practice computer medical records system was used to identify review dates, which enabled staff to schedule appointments.

The practice had systems in place to identify people aged over 75; each person had a named accountable GP in line with the recent GP 2014 to 2015 contract changes. The practice showed us they had a good uptake of flu vaccinations for patients 75 years and over. They had also encouraged the uptake for shingles vaccination; at least half the patients eligible for treatment had already received it.

Are services effective?

(for example, treatment is effective)

We found that although staff had not received specific training to understand the needs of older people, we saw the staff were polite, patient and helpful with older people whilst trying to book appointments and assist them with their enquiries. Staff told us they recognised patients' individual needs such as limited mobility or difficulties reading or writing and tried to support them.

The practice told us they monitored the emergency admissions and reviewed all unplanned admissions or readmissions for patients over 75years of age in order to ensure that these had been appropriate and unavoidable These reviews involved a medication review within 72 hours of patients being discharged from hospital in order to prevent future inappropriate or avoidable hospital admissions.

The practice identified those people with long term conditions at the practice and placed them on a clinical register to oversee and maintain their care. Where appropriate, patients had been appointed a clinical lead to co-ordinate and oversee their care, this included assistance and support to self-manage their conditions. We found patients had been advised with regards to specialist services they could access to meet their individual needs and had been signposted to additional support networks to assist them.

The practice accommodated the midwifery service every Monday morning to provide local antenatal care. This meant only those mothers at the practice that needed consultant led antenatal care needed to attend the hospital to meet their antenatal needs. Expectant mothers' needs were assessed individually and their care plans reflected this, for example, receiving general information on healthy lifestyle choices and how to access community services and support networks The practice told us there was a good up-take rate for pregnant mothers having received the flu vaccine this year.

We found that clinical and administrative staff had received safeguarding training to recognise and respond to safeguarding concerns. We saw there was a system in place for the timely identification and management of children where safeguarding concerns were identified.

The practice had five children with complex health needs and these children required a multidisciplinary approach to the management of their health conditions. Staff told us that detailed care plans were in place and that the practice supported the children's' carers.

The practice provided screening clinics and signposting for working age people. These included family planning, contraception and follow-up, cervical smears, health advice regarding lifestyle, diet, smoking and alcohol intake, new patient health checks and chlamydia screening.

The practice showed us how they monitored the needs of their vulnerable patients via their risk register. They explained they had responsive support care plans in place to ensure patients felt able to access timely and appropriate care. They also identified alerts from the Clinical Commissioning Groups regarding patients who potentially abused substances or were missing locally.

We asked staff what training and support they were given to enable them to recognise and respond appropriately to the needs of vulnerable patients. Staff said they felt comfortable supporting patients who may experience difficulty communicating, have mobility issues or present differently from others due to their lifestyle choices.

Staff had also been taught to recognise and escalate health concerns to the clinical team by the appointed lead clinician responsible for this population group at the practice.

The practice monitored the A&E admissions of people experiencing poor mental health or had attended due to self-harm. The practice told us they were not currently involved in any mental health assessments, guardianship orders, or deprivation of liberty orders.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We asked the practice about the way they assisted patients when they were bereaved. We were told patients were offered appointments with their GP. Patients did not have access to bereavement literature but were provided with contact details of specialist services. We asked what training and support staff were given to meet patient's individual needs and ensure they were treated with respect and compassion. Some staff had undertaken patient care training which included how to communicate with patients experiencing reduced circumstances. We saw staff were required to undertake equality and diversity training. We looked at staff personnel records that confirmed staff had received this training.

Staff told us they identified and tried to meet the individual needs of patients such as those with learning or physical disabilities. During a physical or intimate examination staff offered patients a chaperone. The Chaperone service was made known to patients by staff members and notices were displayed throughout the service. A chaperone is a person who is present as well as the person who is examining you. All patients (male and female) are entitled to have a chaperone present when an intimate examination or procedure will take place.

Where difficult or sensitive messages had to be conveyed, staff ensured the person was given sufficient time with the GP so they could fully explain and support them. We saw and people told us that staff respected and observed confidentiality. There were facilities available so patients could speak privately with staff so they were not overheard by others. People told us that they were never interrupted during a consultation with the doctor and their dignity was respected at all times.

Care planning and involvement in decisions about care and treatment

When patients registered at the practice they were asked to give their preferences for care and treatment to enable the practice to provide individualised care. Where people lacked capacity to make decisions or required additional support to make decisions, clinical staff acted in accordance with the mental capacity act. Staff demonstrated that they were aware of the Mental Capacity Act (MCA) and how it may relate to patients. The Mental Capacity Act (MCA) (2005) is designed to protect patients who may require support to make decisions which are in their best interest. Clinicians told us where a patient may not have capacity or required additional support to make a decision, they worked with South Essex Partnership Trust (SEPT) providing community health services in South Essex, West Essex and Bedfordshire, district nursing teams, carers and/or family. The practice has worked with care homes for elderly residents and people with learning and physical disabilities to develop understanding of patients' needs and how best to meet them. However, where necessary, best interest decisions were well documented by the GP.

Clinician's demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. A Parent told us staff confirmed their relationship with their child and whether they agreed that their child could be immunised before care was provided.

We found patients have been surveyed regarding their experiences in October 2013 and 141 patients had participated in the survey. Overall the patients found the service accessible and the staff helpful. Patients believed they were listened to, tests and treatments were explained and they were involved in making decisions about their care.

Staff told us that all concerns raised by patients were documented on their record and brought to the attention of the practice manager if they were unable to resolve them immediately. NHS leaflets were also available within reception encouraging patients to provide feedback on the service. Patients told us they valued the opportunity of seeing the same doctor and found them to be very caring and were treated well.

Patient/carer support to cope emotionally with care and treatment

Where family, friends and advocates were involved in the care of patients registered at the practice, this was recorded on their medical records and disclosures were made in accordance with the patient's wishes. Verbal and written information is provided to patients to assist them to understand the assessment, diagnosis and treatment options available. Patients were also referred to other sources of information such as websites and community

Are services caring?

support groups to assist them. By identifying those people with caring responsibilities this enabled staff to consider these responsibilities when discussing care and arranging appointments to ensure they were suitable for patients.

In addition, we found the practice monitored the mental health needs of patients to ensure they could access services and were supported throughout their care. Staff had also been taught to recognise and escalate health concerns to the clinical team by the appointed lead clinician responsible for those patients with mental health needs at the practice.

We found that although staff had not received detailed training to understand the needs of older people, we saw the staff were polite, patient and helpful with older people whilst trying to book appointments and assist them with their enquiries. Staff told us they recognised patient's individual needs such as limited mobility or difficulties reading or writing and tried to support them.

Where concerns were identified with regard to physical and/or mental health of a child, appropriate and timely referrals to partner agencies were made and documented.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We asked the practice how they responded to and acted to meet patients' needs and wishes. The practice was able to demonstrate that they had responded to the concerns of patients. For example, the practice had changed their appointment system in response to patient concerns raised through their PRG.

We found the practice offered a range of specialist clinics including but not exclusively diabetes, asthma, COPD.

Tackling inequity and promoting equality

We found the needs and wishes of people with learning disabilities were met. The practice held a register of patients who were vulnerable due to their learning disability in order to ensure that their changing health needs were monitored and met. The practice also regularly reviewed those patients living in residential care.

The doctor spoke four languages, and the staff had access to translation service, this was explained in the patient leaflet and on the practice website.

Access to the service

Patient could make appointments on the telephone, in person, and online for those patients who had signed up for the system. The practice offered flexible access to the service by increasing the duration of some appointments, offering telephone appointments and home visits whilst delivering care jointly with other community health professionals. Longer appointments were offered where needed for older people, people with long-term conditions and complex needs, home visits were given to those patients who were unable to travel to the practice. We saw that consideration had been given to the appointment system and availability for children outside the school open hours to ensure the access to health provision. For working age people who attend and contacted the practice, we were told the practice offered extended opening hours, telephone consultations; ring backs, and priority appointments. The practice had also introduced online booking and a text reminder system for those patients who had signed up for it. Where concerns had been raised regarding the living standards of a person the practice had worked with the person and social care to access the care and support they needed. Staff had also been taught to recognise and escalate mental health concerns to the clinical team by the appointed lead clinician responsible for mental health at the practice.

We asked the service about access to medical services when the practice is shut. The practice had opted out of providing out of hours care and subscribed to a local out of hours service to answer calls and refer patients. Information regarding this service was available within the practice on the practice leaflet and on the practice website.

The doctor at the practice could speak four languages and they used the translation service if access to another language was needed.

Due to the nature of the building there was access for patients with reduced mobility and there were disabled parking facilities. Home visits were available to see patients who were frail or too unwell to attend the practice. These were usually carried out after morning appointments or sooner if urgent.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy is in line with recognised guidance and contractual obligations for GPs in England and there is a designated responsible person who handles all complaints in the practice. The practice leaflet explains how the practice deals with complaints, concerns and comments and a poster in reception signposts the local 'Making Experiences Count Team' and a contact number. We saw complaints were responded to appropriately, apologies were given where appropriate and investigated in a timely way.

We noted staff members had signed to acknowledge receipt of the whistleblowing policy; this was up to date and had been reviewed.

Are services well-led?

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

Our findings

Vision and Strategy

We saw that the practice had a vision statement within their practice leaflet – 'Patients come first'. This outlined their aim to deliver genuinely caring and patient-centred services.

We also saw the practice's 'statement of purpose' which listed their aims and objectives for the service. However, some staff told us they did not feel able to influence the vision for the practice because it was owned by a large organisation. They commented that their hard work and achievements were not always recognised.

Governance Arrangements

Governance arrangements were overseen by the primary care company that owned the practice; this included the systems that governed serious incidents, complaints and practice risks. Reports were run on a monthly basis and the status checked to ensure work was completed appropriately and in a timely fashion.

We saw the practice had achieved an overall level two for information governance using the 'information governance (IG) toolkit'. The IG toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health IG policies and standards. It also allows members of the public to view participating organisations' IG toolkit evaluations. Level two is a satisfactory achievement for primary care services using this toolkit.

Leadership, openness and transparency

The practice used the Quality and Outcomes Framework (QOF) as a performance monitoring outcome tool. This is an annual clinical quality incentive programme designed to reward good practice. The practice was able to demonstrate that their data and review performance had improved considerably over the last 18 months.

The practice leadership is maintained by the company that owns the practice. The staff follow the corporate documentation used by the organisation. We found this to be up to date and recently reviewed.

Practice seeks and acts on feedback from users, public and staff

The practice had an active and well represented patient reference group (PRG) and we were told they met monthly with the practice and that, in addition, weekly, or daily conversations sometimes took place The PRG chair told us how the community valued the location, staff and services offered at the practice. The group was focused and pragmatic in their work with the service and concentrated on the provision of accessible and sustainable services. This was evident with the practices and PRG's commitment to operate open clinics enabling patients to attend and receive care and treatment to meet their individual needs e.g. asthma, diabetes. The PRG told us they were listened to and valued within the community, by the practice and staff.

We were also told by the PRG that the practice manager was extremely well thought of by staff and patients. They told us the practice manager was known for addressing issues as soon as requested and for being both respectful of patient choices and responsive to their individual needs. The primary care company was also well regarded by the PRG. The company had met with them and explained and provided reassurance regarding proposed changes of premises.

Staff felt supported by the practice manager and GP. They told us they would not hesitate to raise concerns and felt confident they would be well received and acted upon. We found a whistle blowing policy was available to staff. This was up to date and had been reviewed.

Management lead through learning & improvement

Patient involvement was encouraged by the practice and PRG. Staff were updated on the outcome of patient surveys and actively engaged in the redefining of the appointment system in response to patient concerns. All parties had worked closely, listening and considering how to enhance the accessibility of the appointment system. The doctor had trained the administrative staff to recognise and escalate patient concerns to enable more timely and appropriate prioritisation of patients. This had been positively received by patients registered at the practice and the staff.