Dr Mahmud & Partners

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?	Requires improvement
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 Dr Mahmud & Partners 10 August 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. Lessons learnt were shared to make sure action was taken to improve safety in the practice.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect. However some aspects of GP interactions with patients and access to care and treatment were rated below the local and national averages. Despite the improvements implemented since the last national GP patient survey these improvements had not filtered through in positive patient responses in the latest 2017 national GP patient survey.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Six out of eight patients we spoke with said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw one area of outstanding practice:

Summary of findings

A dedicated GP provided pre diabetic care and proactively managed medicine compliance and diabetes reviews regularly through reminder letters, phone calls or text messages. This work had resulted in targeted management of patients with diabetes, for example good control in blood glucose readings of patients with diabetes. This GP also provided training for GPs and nurses to raise the standards of diabetes care and to provide individualised care for patients. The training is called the EDEN project (Effective Diabetes Education Now). The GP had published a paper in a health journal about management of blood glucose in type 2 diabetes and had contributed to a section about when to intensify glucose lowering therapy in the prescribing reference guide (MIMS) for general practice. Their contribution to diabetic care was recognised by the Castle Point and Rochford Clinical Commissioning Group (CCG) as a model for use within the wider local health community.

The areas where the provider should make improvement are:

- Undertake an annual infection control audit.
- Continue to identify and support carers.
- Continue to monitor and ensure improvement in patient satisfaction as highlighted in the areas identified by the national GP patient survey.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events. Staff we spoke with confirmed lessons were shared.
- When things went wrong patients were informed as soon as practicable, received support, information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- There were arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Latest data from the Quality and Outcomes Framework 2015 – 2016 showed patient outcomes were comparable with or above average compared to the national average. For example the percentage of patients with chronic obstructive pulmonary disease (COPD)who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 92%, compared to the CCG average of 86% and the national average of 90%. Staff were aware of current evidence based guidance.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the most recent national GP patient survey published July 2017 showed patients were treated with compassion, dignity and respect. However some aspects of GP interactions with patients and access to care and treatment were rated below the local and national averages.
- Patients we spoke with and comment cards showed that patients were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- The practice had identified patients who were also carers. GPs helped ensure that the various services supporting carers were coordinated and effective.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example the practice was working towards establishing an in-house vasectomy service, and setting up an obesity service to improve local access to these services.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below the local and national averages. For example, 40% of patients said they could get through easily to the practice by phone compared with the CCG average of 62% and the national average of 71%.
- Two patients we spoke with were dissatisfied with getting through to the practice to make an appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders as appropriate.

Summary of findings

Are services well-led?

Good

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

- The practice had aims and plans to deliver high quality care and promote good outcomes for patients. Staff were knowledgeable about the aims and plans and their responsibilities in relation to it.
- There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was a governance framework which supported the delivery of good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In two examples we reviewed we saw evidence the practice complied with these requirements.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group (PPG).
- There was a strong focus on continuous learning and improvement at all levels.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients. For example diabetes care and pain control.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- Patients over 75 had a named accountable GP and were offered the over 75 health check.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- For the housebound patient the practice monitored essential wellbeing, medicine compliance and current health needs through telephone consultations.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible. For example eligible older people were offered flu and shingles vaccines.
- The practice supported one care/nursing home. A dedicated GP visited weekly to provide a ward round and provide healthcare including preventative care such as against osteoporosis, deep vein thrombosis (DVT) and skin care.

People with long term conditions

Good

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

- GPs supported by nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- Performance for diabetes related indicators was comparable to the local and national averages. The practice achieved 85% of available points compared to the CCG average of 82%.
- A dedicated GP provided pre diabetic care and proactively managed medicine compliance and diabetes reviews regularly through reminder letters, phone calls or text messages.
- A dedicated GP provided in house pain control for the oncology and palliative care patient helping them to manage pain control without the need to attend an acute care facility.
- There was a system to identify patients at risk of hospital admission that had attended A&E or the out of hours service and these patients were regularly reviewed to help them manage their condition at home.
- The practice offered monitoring of condition and medicine which required blood tests for example patients on warfarin, chemotherapy or immunotherapy.
- Patients with osteoarthritis were offered in-house joint injections.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met.
- For patients with more complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

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

- There were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice's uptake for the cervical screening programme was 83%, compared to the CCG average of 86% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice opportunistically provided joint family clinical assessment.

Summary of findings

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice offered family planning including the management of intrauterine system and related screening such as chlamydia screening.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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.
- Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal hours.
- The practice had enrolled in the Electronic Prescribing Service (EPS). This service enabled GPs to send prescriptions electronically to a pharmacy of the patient's choice.
- 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.
- A text message reminder system was used so patients could be reminded of forthcoming appointments or sent a short message for example about a normal test result.
- University students were offered confidential or general clinical advice routinely.

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.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

Summary of findings

- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The practice identified patients who were also carers and signposted them to appropriate support. The practice had identified 51 patients as carers (less than 0.5% of the practice list). of the practice list). The GPs provided information and directed carers to the various avenues of support available to them. The practice offered carers health checks and flu vaccinations.

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).

- The practice carried out advance care planning for patients living with dementia.
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 87% where the CCG average was 75% and the national average was 84%.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with diagnosed psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94% where the CCG average was 79% and the national average was 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access a number of support groups and voluntary organisations.

Summary of findings

- The practice had a system to follow up patients who had attended A&E where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2017. The results showed the practice performance in comparison with local and national averages. 255 survey forms were distributed and 115 were returned. This represented 51% return rate (less than 1% of the practice's patient list).

The results showed:

- 72% of patients described the overall experience of this GP practice as good compared with the CCG and the national average of 85%.
- 58% of patients described their experience of making an appointment as good compared with the CCG and the national average of 73%.
- 58% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. All of the 31 patient comment cards we received were positive about the care experienced. Patients noted that their care experience was positive and that the practice staff had looked after their needs in a friendly and accommodating way. Staff had listened to them and had cared for them in a very professional way with dignity and respect. GPs had given them time and supportive to their needs. There were positive comments about the reception staff including that they were polite and helpful. Two comment cards noted that it was hard to obtain an appointment with a GP on the day through the telephone appointment system.

During the inspection we spoke with eight patients. They told us the care received had been entirely professional and caring. Comment cards highlighted that staff responded with compassion and understanding when they needed help and provided support when required. Two patients we spoke with on the day of the inspection told us that they had waited up to 20 minutes to be connected to the receptionist to book an on the day appointment when they had rung at 8am.

Areas for improvement

Action the service SHOULD take to improve

- Undertake an annual infection control audit.
- Continue to identify and support carers.
- Continue to monitor and ensure improvement in patient satisfaction as highlighted in the areas identified by the national GP patient survey.

Outstanding practice

We saw one area of outstanding practice:

- A dedicated GP provided pre diabetic care and proactively managed medicine compliance and diabetes reviews regularly through reminder letters, phone calls or text messages. This work had resulted in targeted management of patients with diabetes, for example good control in blood glucose readings of patients with diabetes. This GP also provided training for GPs and nurses to raise the standards of diabetes care and to provide individualised care for patients. The training is called the EDEN project (Effective Diabetes Education Now). The GP had published a paper in a health journal about management of blood glucose in type 2 diabetes and had contributed to a section about when to intensify glucose lowering therapy in the prescribing reference guide (MIMS) for general practice. Their contribution to diabetic care was recognised by the Castle Point and Rochford Clinical Commissioning Group (CCG) as a model for use within the wider local health community.

Dr Mahmud & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Mahmud & Partners

Dr Mahmud & Partners situated at Burley House 15 High Street, Rayleigh, Essex is a GP practice which provides primary medical care for approximately 14,800 patients living in Rayleigh and the surrounding areas. There is a branch, the Jones Family Practice, situated in Southend Road, SS5 4PZ at the nearby village of Hockley. The practice maintains one patient list and patients can consult at any of the above locations. We did not inspect the Hockley branch at this time.

Dr Mahmud & Partners provide primary care services to local communities under a General Medical Services (GMS) contract, which is a nationally agreed contract between general practices and NHS England. The practice population is predominantly white British along with a small ethnic population of Asian and Eastern European origin.

The practice currently has five GPs partners (two female and three male). There are two other male salaried GPs. The registered manager told us that the practice was in the process of changing their partnership. There are two practice nurses who are supported by two health care assistants and a phlebotomist. There is a practice manager who is supported by a team of administrative and reception staff. The local NHS trust provides health visiting and community nursing services to patients at this practice.

The practice operates out of a two storey building. Patient care is provided on the ground floor. There is a pay and display car park nearby with disabled parking available on the main street near the practice.

The practice is open Monday to Friday from 8am to 6.30pm. There are a variety of access routes including telephone and web consultations, on the day appointments and advance pre bookable appointments.

When the practice is closed services are provided by Integrated Care 24 Limited via the 111.

Why we carried out this inspection

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

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 10 August 2017. During our inspection we:

Detailed findings

- Spoke with a range of staff including the GPs, nursing staff, administration and reception staff and spoke with patients who used the service.
- Observed how patients were being assisted.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- The staff we spoke with told us they would inform the practice manager or a GP of any incidents and there was a recording form available. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed a sample of three from the documented significant events log and found that when things went wrong with care and treatment, the patient was informed of the incident as soon as reasonably practicable, received support, information, an apology and were told about any actions to improve processes to prevent the same thing happening again. For example we saw the practice had contacted a patient following a prescription incident with an apology explanations and reassurance that the practice policy had been updated with related staff training to avoid a repetition.
- We saw that significant events were discussed, reviewed and action points noted at least every six weeks. Learning points were shared through two forums, clinical and administrative as appropriate. Individual actions were taken forward by the practice manager with whole practice learning disseminated through monthly learning events.
- We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. For example following a clinical incident the practice had made sure all prescribers were made aware of the prescribing guidelines related to the repeat prescribing of a medicine to lower the level of cholesterol in the blood.
- Patient safety alerts and MHRA (Medicines and Healthcare Regulatory Agency) alerts were received into the practice by the practice manager and disseminated to the appropriate staff for action. We noted appropriate actions were taken following receipt of alerts. For example we reviewed a patient safety alert related to a medicine used to treat epilepsy and bipolar disorder and occasionally used to treat migraine or chronic pain. We found that the practice had acted on the recommendations and ensured girls and women of childbearing potential were prescribed this medicine with caution.

Overview of safety systems and processes

The practice had defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A summary sheet about safeguarding with contact details was available in each consultation and clinical room. A designated GP was the lead for safeguarding. The GPs provided reports, attended safeguarding meetings and shared information with other agencies where necessary. The Lead GP also attended the CCG safeguarding lead forum held every three months. Safeguarding risks were discussed at clinical meetings with appropriate communication/referral made as appropriate, for example to the Health Visitor with the relevant patient electronic record updated. The practice was in the process of arranging regular meetings with the Health Visitor. The electronic patient record had a marker to alert staff to a patient with safeguarding needs.
- Staff demonstrated they understood their responsibilities. For example we saw that following a review of patients attending A&E the practice had referred a patient with an unexplained head injury to the Health Visitor for a follow up review to ensure their safety and wellbeing. Staff had received the appropriate level of safeguarding training for their role. GPs were trained to the appropriate level to manage child (level 3) and adult safeguarding.
- A notice in the waiting and clinical rooms advised patients that chaperones were available if required. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS)

check. (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 maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. Hand wash facilities, including soap dispensers were available throughout the practice. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice.
- There was an IPC protocol and staff had received up to date training. Daily and six weekly targeted infection control audits were undertaken, for example to check clinical rooms, instruments and we saw evidence that action was taken to address any improvements identified as a result. However we did not see evidence of a comprehensive annual IPC audit.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. We checked patients that received high risk medicines and found they were appropriately monitored.
- The practice carried out regular medicines audits, independently and with the support of the Castle Point and Rochford CCG medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing. For example the practice had worked with the CCG to achieve optimisation of prescribed medicines for patients that received oral medicines for type 2 diabetes.
- Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- Patient Group Directions had been adopted by the practice to allow the practice nurse to administer medicines in line with legislation. The health care assistant was trained to administer medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients to vacate the premises.
- All electrical and clinical equipment had been checked and calibrated to ensure it was safe to use.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and a risk assessments against a trip hazard had resulted in electrical wire trunking being installed.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an electronic rota system to ensure enough staff were on duty to meet the needs of patients. The rota system allowed staff to book leave and other planned absence as well as arrange cover for unplanned absence.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Good

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Key points of the guidance and changes in practice were discussed during regular clinical meetings. For example we saw that a lead GP had updated all clinical staff with the latest guidelines related to the treatment of patients with diabetes.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 95% of the total number of points available compared with the CCG average of 91% and national average of 95%.

Data from 2015/16 showed:

- Performance for diabetes related indicators was comparable to the local and national averages. The practice achieved 85% of available points, with 5% exception reporting, compared to the CCG average of 82%, with 8% exception reporting, and the national average of 90%, with 12% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

For example the percentage of patients with diabetes, on the register, in whom the last blood glucose reading showed good control in the in the preceding 12 months was 81%, compared to the CCG average of 74% and the national average of 78%. Exception reporting for this indicator was 3% compared to a CCG average of 7% and the national average of 13%.

- Performance for mental health related indicators was comparable to the local and national averages. The practice achieved 99% of available points, with 10% exception reporting, compared to the CCG average of 87%, with 8% exception reporting, and the national average of 93%, with 11% exception reporting.

  For example the percentage of patients with diagnosed psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94% where the CCG average was 79% and the national average was 89%. Exception reporting for this indicator was 12% compared to a CCG average of 9% and national average of 13%.

- Performance for dementia related indicators was comparable to the local and national averages. The practice achieved 95% of available points, with 12% exception reporting, compared to the CCG average of 90%, with 12% exception reporting, and the national average of 97%, with 13% exception reporting.

For example the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 94% where the CCG average was 79% and the national average was 89%. Exception reporting for this indicator was 12% compared to a CCG average of 9% and national average of 13%.

We reviewed the exception reporting and found that the practice had made every effort to ensure appropriate decision making including prompting patients to attend for the relevant monitoring and checks. Discussions with the lead GP showed that procedures were in place for exception reporting as per the QOF guidance and patients were reminded to attend three times and had been contacted by telephone before being subject of exception.

There was evidence of quality improvement including clinical audit:

Good

Are services effective?

(for example, treatment is effective)

- We looked at five clinical audits undertaken in the past two years; two of these were completed audits where the improvements made were implemented and monitored. A system was in place to ensure re auditing took place on a rolling programme.
- The practice participated in local audits, national benchmarking, peer review and research.
- Findings were used by the practice to improve services. For example following an audit of uptake of bowel cancer screening the practice had identified patients who had not attended and had implemented processes to encourage these and others to attend.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety governance and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions such as diabetes asthma wound care and COPD (chronic obstructive pulmonary disease).
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, and support for revalidating GPs and nurses. Staff had received an annual appraisal in the past 12 months and staff we spoke with confirmed that this was a positive productive experience.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. They had access to and made use of e-learning training modules and in-house training.

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Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients with palliative care needs to other services including with the out of hours service and community nursing services.
- There was a process to communicate with the district nurse and health visitor.
- The pathology service were able to share patient clinical information and results electronically.
- There was a system to review patients that had accessed the NHS 111 service and those that had attended the A&E department for emergency care.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. Meetings took place with other primary health care professionals at least monthly when care needs routinely reviewed and updated as needed.
- A dedicated GP provided in house pain control for the oncology and palliative care patient helping them to manage pain control without the need to attend an acute care facility.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Signed consent forms were used for minor surgery and scanned into the electronic patient record.
- Verbal consent was obtained prior to insertion of an intrauterine device (IUD or coil) which was recorded on the patient's records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers and those at risk of developing a long-term condition, those patients with mental health problems and patients with learning difficulties were offered regular health reviews and signposted to relevant support services.
- We saw a variety of health promotion information and resources both in the practice and on their website. For example, on family health, long term conditions and minor illness.
- A dedicated GP provided pre diabetic care and proactively managed medicine compliance and diabetes reviews regularly through reminder letters, phone calls or text messages.
- The practice's uptake for the cervical screening programme was 83%, compared to the CCG average of 86% and the national average of 81%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a consequence of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Results showed:

- 73% of females, aged 50-70 years, were screened for breast cancer in last 36 months compared to the CCG average of 71% and the national average of 73%.
- 64% of patients, aged 60-69 years, were screened for bowel cancer in last 30 months compared to the CCG average of 60% and the national average of 58%.

Childhood immunisation rates for vaccinations given were above national averages. The practice achieved 98% against the national target of 90% in four out of the four indicators for childhood immunisations given to under two year olds.

For five year olds, the practice achieved an average of between 96% and 99% (national averages ranged between 88% and 98%) for MMR vaccinations.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. In the year 2016/17, the practice had undertaken 526 health checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 31patient Care Quality Commission comment cards we received were positive about the care experienced. Patients noted that their care experience was positive and that the practice staff had looked after their needs in a friendly and accommodating way. Staff had listened to them and had cared for them in a very professional way with dignity and respect. GPs had given them time and supportive to their needs. There were positive comments about the reception staff including that they were polite and helpful.

We spoke with eight patients. They told us the care received had been entirely professional and caring. Comment cards highlighted that staff responded with compassion and understanding when they needed help and provided support when required.

Results from the national GP patient survey showed:

- 73% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 72% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 89% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national average of 95%
- 66% of patients said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 83% and the national average of 86%.
- 91% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 89% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 99% and the national average of 97%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 76% of patients said they found the receptionists at the practice helpful compared with the CCG and the national average of 87%.

The practice had analysed the previous national GP patient survey results and developed a detailed action plan to improve patient experience. For example to improve satisfaction with receptionists, the practice had introduced customer care training. The GPs were aware of the lower than average scores for some aspects of interaction with patients. Two GPs had recently completed a post graduate programme in education and had provided training to clinical staff on communication skills in February 2017. The practice anticipated that future survey results would show an improvement as a result of the changes made.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Good

Are services caring?

Most recent results from the national GP patient survey published July 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were broadly in line with local and national averages. For example:

- 77% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 86%.
- 62% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 79% and the national average of 82%.
- 90% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 90%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information was available in the patient waiting area as well as on the practice website which 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. The practice had identified 51 patients as carers which equated to less than 0.5% of the practice list. The GPs and nurses directed carers to a number of services available to them ensuring they were supported in a coordinated and effective way. New carers were invited to complete a carer registration form and were provided with written information about support available to them. Carers were offered flu and pneumococcus vaccinations as appropriate.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice was open Monday to Friday from 8am until 6.30pm.
- The practice provided a ring back service by a duty GP or a nurse at the patient's request where appropriate.
- The practice offered web based GP consultations which was a first within the Castle Point and Rochford Clinical Commissioning Group (CCG).
- There were longer appointments available for patients with a learning disability and others with complex needs.
- Home visits were available by a GP for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- For the housebound patient the practice monitored essential wellbeing, medicine compliance and current health needs through telephone consultations.
- The practice supported one care/nursing home. A dedicated GP visited weekly to provide a ward round and provide healthcare including preventative care such as against osteoporosis, DVT and skin care.
- Patients over 75 had a named accountable GP and were offered the over 75 health check.
- The practice offered flu and shingles vaccines for older people and other people at risk who needed these vaccinations.
- The practice provided specialist clinics for diabetes, chronic obstructive pulmonary disease (COPD), asthma, and anticoagulation.
- The practice offered monitoring of condition and medicine which required blood tests for example patients on warfarin, chemotherapy or immunotherapy.
- Patients with osteoarthritis are offered in-house joint injections.
- Patients had access to onsite counselling sessions provided by the local mental health trust.
- There was a system to identify patients at risk of hospital admission that had attended A&E or the out of hours service and these patients were regularly reviewed to help them manage their condition at home.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice opportunistically provided joint family clinical assessment.
- The practice offered family planning including the management of intrauterine system and related screening such as chlamydia screening.
- University students were offered confidential or general clinical advice routinely.
- Patients were able to receive travel vaccinations available on the NHS.
- There were disabled facilities and translation services available.
- Online services were available for booking appointments and request repeat prescriptions.
- Through the Electronic Prescribing System (EPS) patients could order repeat medicines online and collect the medicines from a pharmacy near their workplace or any other convenient location.

Access to the service

The practice was open Monday to Friday from 8am until 6.30pm. The practice did not offer extended openings. However the lead GP told us that they were currently considering extended opening times.

Results from the national GP patient survey published in July 2017, showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 53% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average and the national average of 76%.
- 40% of patients said they could get through easily to the practice by phone compared with the CCG average of 62% and the national average of 71%.
- 81% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 87% and the national average of 84%.
- 76% of patients said their last appointment was convenient compared with the CCG average of 85% and the national average of 81%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 58% of patients described their experience of making an appointment as good compared with the CCG average and the national average of 73%.
- 51% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 68% and the national average of 58%.

Two comment cards noted that it was hard to obtain an appointment with a GP on the day through the telephone appointment system. Two of the eight patients we spoke with on the day of the inspection told us that they had waited up to 20 minutes to be connected to the receptionist to book an on the day appointment when they had rung at 8am.

The practice was aware of the lower satisfaction in relation to telephone access and on the day appointments. The practice manager told us that they had introduced a number of improvements. These included:

- Commenced discussions to consider extended opening hours.
- Ordered a new telephone system to be installed by December 2017 which was user friendly and which gave the caller their status in the queue.
- Commissioned a review of the appointment slots available each day with a view to increasing these including by the use of telephone and web consultations.
- Advertised widely the availability of telephone and web based consultations.
- Introduced customer care training for receptionists to improve patient experience when making an appointment.
- Monitored consulting times of each GP to check how well the ten minute consultations were being kept. The practice had identified factors that extended consultations beyond ten minutes, for example multiple health issues. The practice has commenced a programme of informing patients of the need to book extended appointments if they wished to discuss multiple health issues.

However despite the improvements implemented since the last national GP patient survey these improvements had not filtered through in positive patient responses in the latest 2017 national GP patient survey. The practice anticipated that future survey results would show an improvement as a result of the changes made.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The reception staff were all aware of how to deal with requests for home visits and if they were in any doubt would speak to a member of the clinical duty team or a GP. Home visit requests were referred to a GP who assessed and managed them as per clinical needs.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- One of the GPs was the designated responsible person who handled all complaints in the practice with support from the practice manager.
- We saw that information was available to help patients understand the complaints system. For example, complaints leaflets were available at the reception desk and there was information on the practice website.

We looked at a sample of the 13 complaints received in the last 12 months and found these had been handled and dealt with in a timely way with openness and transparency. Lessons were learned from individual concerns and complaints. Action was taken to as a result to improve the quality of care. For example, following a complaint about dissatisfaction at not being able to secure a routine appointment with a particular doctor, we saw that the practice had responded to the complainant giving an explanation of the GP rota individual GP availability and the appointment system. We also saw that the practice had offered an apology for the inconvenience caused.

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 vision to deliver high quality care and promote good outcomes for patients.

- The practice vision was to empower the patients into self-management of common ailment.
- They aimed to improve public awareness of breast, colorectal and prostate cancers so early treatment provided a better chance of good prognosis.
- They aimed to improve patient understanding and compliance of medicine with chronic disease management through patient partnership.
- The practice was aware of the lower than average scores for some aspects of interaction with patients as well as access and had immediate and mid-term plans to improve satisfaction.
- The practice had a five year forward plan to ensure it remained accessible and cost effective. Examples of improvements included signing up to the extended GP opening hours, offering an in-house vasectomy service, becoming a training practice for GPs and setting up an obesity service.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example a GP led on diabetes and cardiovascular disease and a practice nurse led on asthma and COPD.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The practice prioritised safe, high quality and compassionate care. Staff told us the GPs and the practice manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty.

We saw two documented example from the past 12 months that we reviewed and found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people support and explanation.
- They kept written records of verbal interactions as well as written correspondence.

There was a leadership structure and staff felt supported by management.

- The practice held a range of meetings including multi-disciplinary meetings with district nurses to monitor vulnerable patients. GPs communicated regularly with health visitor to monitor vulnerable families and safeguarding concerns. The lead GP for safeguarding was arranging regular face to face meetings with the health visitor.
- Staff told us the practice held regular team meetings every usually every month.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

- A dedicated GP provided pre diabetic care and proactively managed medicine compliance and diabetes reviews regularly through reminder letters, phone calls or text messages. This work had resulted in targeted management of patients with diabetes, for example good control in blood glucose readings of patients with diabetes. This GP also provides training for GPs and nurses to raise the standards of diabetes care and to provide individualised care for patients. The training is called the EDEN project (Effective Diabetes Education Now). The GP had published a paper in a health journal about management of blood glucose in type 2 diabetes and had contributed to a section about when to intensify glucose lowering therapy in the prescribing reference guide MIMS for general practice. Their contribution to diabetic care was recognised by the CCG as a model for use within the wider local health community.
- The practice manager had been awarded a certificate of excellence By the Essex Medical Society (a peer support organisation for GPs in Essex) for outstanding performance dedication and continuing excellence in exemplifying the highest standards of service as a practice manager.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback:

- There was a patient participation group (PPG). We reviewed the minutes of the last PPG meeting held in July 2017. We noted that the practice had shared information about the services offered such as the appointment system, electronic prescription service and the forthcoming flu vaccination dates. The practice had also shared the latest patient survey results and asked members to contribute ideas to ensure improvements to patient satisfaction.
- The practice had 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. They told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. For example:

- In response to lower patient satisfaction with access the practice had introduced web GP consultation, a first in the local CCG area.
- Two GPs had completed a teaching qualification in order to provide training facilities for new GPs.