The Tollesbury Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Tollesbury Surgery on 10/03/2015. Overall the practice was rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed, addressed and shared with staff during meetings.
- Risks to patients were assessed and managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned for.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was readily available and easy to understand. Complaints were investigated and responded to appropriately.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice

proactively sought feedback from staff and patients, which it acted on.

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 good for providing safe services. Staff understood their responsibilities around raising concerns, and reporting incidents and near misses. We saw significant events were reported and investigated. The investigations showed lessons had been learnt and shared to support improvement with those that could be affected. Risks to patients and staff were identified and managed. There were procedures in place for identifying vulnerable adults and children and to share information with relevant agencies appropriately. We saw records that enough staff were working at the practice each day to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for their locality and where there were areas for improvement the practice was proactive in addressing these. Staff referred to guidance from National Institute for Health and Care Excellence and ensured patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patient capacity and promoting good health. Staff had received role specific training and where further training needs had been identified the practice was open to plan and meet these needs. There was evidence of appraisals and identify training and development for staff within their documented objectives. Staff worked with multidisciplinary teams to ensure that patients received effective personalised care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice higher than others for several aspects of care, such as how GPs and nurses explained their care to them, involving them in making decisions and listening to them. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services was available and easy to follow. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received very positive remarks on the comment cards we left for patients to complete about their care at the practice. The patients we spoke with during the inspection were

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also positive about the care they received. A healthcare professional we spoke with before inspecting the practice gave us examples of what they called 'above and beyond' caring from the GPs that they had experienced.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the practice patient participation group (PPG) to plan and develop the practice services. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had a flexible appointments system with open surgery in the mornings and booked evening appointments. The majority of patients said they could be seen by a named GP and that there was continuity of care, and patients with an urgent medical problem were always seen the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to any issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff knew what their responsibilities were in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and there was a procedure in place to monitor and improve the quality of service provision and to identify any risks to staff or patients. The practice proactively sought feedback from staff and patients, and saw evidence of actions taken in response to feedback.

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The six population groups and what we found

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

Older people

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP to ensure they were offered proactive, personalised care to meet their individual needs. The practice was proactive in providing 'Senior Health Checks' in the nurse lead clinics. Longer appointments were available for this population group and staff members take into consideration appointments times suitable for carers or relatives to attend when requested. Telephone consultations were also available for advice.

The practice provided both non-urgent and urgent home visits to frail or housebound patients. Each month they held a frailty and palliative care meeting; these involved the wider practice team including district nurses, Macmillan nurses and the community matron. There were three care homes in the practice area, all the patients in these homes were on the frailty registers and received regular pre-arranged reviews.

The uptake of flu vaccination for this population group at the practice was above average compared with other practices in the local area.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed for this population group. The practice maintained disease registers for patients with long-term conditions. Patients in this population group had a named GP, care plan, and many were on the frailty register. All these patients had a structured annual review to check their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a more multidisciplinary package of care.

The practice had specific emergency processes and referrals in place for patients with long-term conditions who experienced a sudden deterioration in their condition.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were processes in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high

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number of A&E attendances. Immunisation rates were high for all standard childhood immunisations in comparable data for the local practices. Patients told us that children and young people were treated in an age-appropriate way. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had recently added a baby changing facility in response to patient feedback. The practice offered full pre-conception antenatal and postnatal care. They had fortnightly appointments available in the surgery with the midwife and had developed a good working relationship with the health visitors. Baby checks and all childhood immunisations were provided. Staff were trained to recognize and deal with acutely ill babies and children and to take appropriate action.

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the 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. Appointments could be booked in person, by telephone or via the practice website. Appointments could be booked up to four weeks in advance and up to 7.30pm one evening per week.

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. There were nurse led clinics held for annual health checks for patients within this population group at the practice each week. There were also NHS Health check clinics available each week for well patients' health checks and the practice provided travel advice and vaccination appointments with the practice nurse team.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and they had received a follow-up. It offered longer appointments for people with a learning disability.

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

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vulnerable adults and children. The practice told us they were well established within the community and knew this patient population group well. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health at the practice had received an annual physical health check. The practice regularly worked with multi-disciplinary teams to implement new care pathways and share care with specialist teams in the case management of people experiencing poor mental health, including those with dementia.

The practice maintained a register of people experiencing poor mental health. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review. The practice referred patients to appropriate services such as psychiatry and counselling services and improving access to psychological therapies (IAPT). IAPT is a programme to improve access to talking therapies in the NHS by providing more local services and psychological therapists. Referrals were made to Child and Adolescent Mental Health Services (CAHMS) to support younger patients and the practice provided a regular carers clinic.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with seven patients visiting the practice on the day of inspection. They were all complimentary with regards to the GPs and staff at the practice. One patient was extremely pleased with the speed of their diagnosis. We were also told by those who received their medicines from the dispensary that the service was excellent and care was taken to explain medicine dosage and use.

There were 29 Care Quality Commission comment cards completed by patients prior to inspection. The comments on 27 of the cards were really positive regarding the practice services, the remaining two cards had less positive comments. Many of the cards commented on the courteous staff at the practice, and how clean and welcoming it was. Some of the cards particularly expressed their satisfaction with the open appointment system in the morning and the ability to book appointments in the afternoon/evening.

The patient participation group report and minutes showed the patients attending the group were given ample opportunity to talk and express their views that influenced the practice decision making.

We spoke with two healthcare professionals before inspecting the practice. One healthcare professional working in the community told us; although the practice used the out of hour's service during the evening and weekends they had seen the GPs visiting patients they were concerned about during the evening and weekends which they felt was extremely caring. They told us the GPs service with regards to patients was 'above and beyond' their requirements. Another professional we had contact with told us they found both GPs very approachable and amenable with regards to any suggestions made around patient care.

The Tollesbury Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission Inspector and a GP specialist advisor.

Background to The Tollesbury Practice

The Tollesbury Practice main surgery is located on the High Street within Tollesbury. There are two branch surgery locations one is at Goldhanger in the village hall, on head street, in Goldhanger, Maldon, Essex. The second we were told was due to close within a month of our inspection and was at Tolleshunt D'Arcy. The practice provides services for approximately 4,000 patients living in and around the Tollesbury and Maldon area of Essex. The practice holds a GMS contract.

Staff members at the practice include, two male GP partners, a regular locum female GP, two practice nurses, three dispensers, a team of six administrative/secretarial/ reception staff and a practice manager who support the practice GPs.

The main surgery was open between 8am and 6.30pm from Monday to Friday and 8am until 7.30pm on Tuesdays. An open surgery was held each morning between 9am and 10.30am and booked appointments each evening Monday to Friday between, 5pm until 6.30pm, with extended hours between 6.30pm until 7.30pm on Tuesday evenings and Thursday and Friday from 4.30pm until 6.30pm.The GoldHanger Branch Surgery was Open between 1.00pm and 1.30pm on Tuesdays and Fridays.

The Tollesbury Practice had opted out of providing out-of-hours services (evenings and weekends). These services were provided by a local out-of-hours service provider 'Prime Care' and details of how to contact the service was available within the practice, on the practice website and in a recorded telephone message.

Why we carried out this inspection

We inspected Tollesbury Practice main surgery as part of our comprehensive inspection programme; we did not inspect the branch surgery.

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

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

How we carried out this inspection

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

Is it safe?

Is it effective?

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Is it caring?

Is it responsive to people's needs?

Is it well-led?

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

Older people

People with long-term conditions

Families, children and young people

Working age people (including those recently retired and students)

People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10th March 2015. During our visit we spoke with a range of staff including two GP's, a practice nurse, the practice manager, two dispensers, receptionists and administrative staff. We spoke with patients who use the service, observed how staff interacted with and welcomed patients to the practice, and reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety including incidents, comments, complaints and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff members told us they were aware of the procedures for reporting and dealing with risks to patients and concerns and those procedures within the practice worked well. Records we viewed showed incidents of a less serious type and near misses were reported, investigated and used to consider safety within the practice.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. Staff told us that information was shared through email notifications and practice meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Through discussions with staff and a review of records we saw that significant events were fully investigated to determine where improvements could be made and to identify learning opportunities to prevent recurrences. We looked at the records in relation to the six significant events reported within the previous twelve months. We found that these had been investigated, and acted upon. Learning outcomes arising from the investigation of these events were shared with staff and periodically reviewed to help prevent any recurrence. Incidents were a standard agenda item discussed within the monthly clinical and administrative meetings. Staff members confirmed these discussions took place.

Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Safeguarding policies and procedures were available to staff which included details of how, and to whom, concerns should be reported. The practice had a designated lead for safeguarding vulnerable adults and children who acted as a resource for the practice. Staff we spoke with were aware who the lead was and who they could speak with if they had any safeguarding concerns.

Practice training records made available to us showed staff had received relevant role specific training on safeguarding adults and children. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns.

There was a method to identify vulnerable patients on the practice electronic records system. This included information for staff regarding any relevant issues when patients attended or failed to attend appointments; for example looked after children (children under the care of the local authority / in foster care) or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed during weekly GP meetings and at monthly multidisciplinary team meetings, which were attended by health visitors, district nurses and other health and social care professionals as required. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed, followed up, and appropriate referrals were made as required.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The chaperone policy described situations and occasions when a chaperone would be required and requested.

Are services safe?

Chaperone duties were undertaken by members of staff that had undertaken chaperone training. Training records we viewed confirmed staff training. Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. Patients were aware they could request a chaperone during their consultation, if they chose to and identified the poster in the waiting room informing patients about this service.

Patients' records were written and kept in a way to keep them safe. The practice electronic system recorded all communications about the patient including scanned copies of communications from hospitals and in addition results from laboratories and x-rays.

Medicines management

We checked the arrangements for the storage of medicines, including vaccines, emergency medicines and medical oxygen. We found medicines were stored at the appropriate temperature to ensure they remained effective. The temperature of fridges used to store medicines was checked daily to ensure they did not exceed that recommended by the medicine manufacturer. We checked a sample of medicines, including those used in a medical emergency and found they were stored, and checked appropriately.

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

The practice followed national guidelines around medicine prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for antibiotics, sedatives and non-steroidal anti-inflammatory medicines were similar to the national average and in line with prescribing guidelines demonstrating that the practice was following local and national guidelines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had arrangements for reviewing patients with long term conditions on a six to 12 month basis to ensure that the medicines they were prescribed and dispensed were appropriate and that risks were identified and managed. When talking with the GPs we were told the arrangements for checking that patients' therapeutic blood levels were checked and medicines were prescribed safely and effectively. Staff told us they followed up patients and encouraged patients to contact the practice for blood test results. Blank prescription forms were handled in accordance with national guidance, tracked through the practice and kept securely at all times.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in practice leaflets and posters in the waiting room and on the practice website. Patients could order repeat prescriptions in person, post, fax, or online via the electronic medical record system.

Patients living more than 1.6 kilometres away from a pharmacy were eligible for the practice dispensing service. Details to obtain medicines using this service were available in person, post, fax, or online via the electronic medical record system. The dispensary offered additional services to practice patients for example disposal of unwanted medication safely, medi-pack dosage system, hosiery measurement and fitting, glucose blood testing monitors, and health information. Dispensing staff told us prescriptions were always signed by the GP before they were dispensed; we saw this was the procedure during the day we inspected.

The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients supplied medicine by the dispensary. The practice held a number of standard operating procedures (SOPs) used by the dispensary staff to support them to provide quality consistent and safe work processes. We found these had been regularly reviewed and were updated appropriately. SOPs are written work procedures that explain a work process in the dispensary from start to finish to keep patients safe. We found the controlled medicines were securely stored and the staff followed the practice SOP procedures. This included an annual self-assessment which we were shown, that established the practice procedures were sufficient and worked well.

Records showed that the staff members involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had established a service for patients to pick up their dispensed medicines at two branch surgery

locations. The practice had a system in place to monitor how these medicines were collected and patients were given the relevant information they needed. The practice procedure was; medicine could only be given to patients who came to collect it by the GPs when they were visiting these locations.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us the repeat prescription service, and the dispensing service worked well and they had their medicines in good time.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We also received comments on the cards left by the Care Quality Commission from patients that told us they found the practice clean, tidy, and a pleasant environment.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example when changing and treating wound dressings. Within the infection control policy there was procedures for handling needle stick injury and staff knew the process to follow if a needle stick injury occurred.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. The practice provided hand gel with a notice 'please use after checking in' on the electronic check in device in the reception area.

Equipment

Staff we spoke with said they had sufficient equipment to carry out the diagnostic examinations, assessments and treatments required at the practice. They told us the equipment was tested and maintained regularly and we were shown equipment maintenance logs and other records that confirmed this. The portable electrical equipment displayed stickers indicating the last testing date, which we noted were within the last year.

Staffing and recruitment

Staff records we looked at held evidence that suitable employment checks had been undertaken before starting work at the practice. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) for those staff member that required these for their roles. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw they had an internal induction process to familiarise new staff members with the practice procedures and processes. A recently recruited member of staff told us this induction had made them feel a useful member of the practice team.

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty to keep patients safe. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

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

Monitoring safety and responding to risk

Are services safe?

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which we noted all staff members had signed to show they understood their role regarding health and safety issues. Health and safety information was displayed for staff to see and the practice had identified two safety officers.

Identified risks were included on a risk log. Each risk was assessed and evaluated and justified actions recorded to reduce and manage the risk. We saw that risks were discussed at meetings. For example, the practice manager had communicated the addition of a baby changing facility.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. There was a prominent sign on the treatment room door stating the practice emergency equipment was stored here.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and explanatory actions recorded to reduce and manage the risk. Example risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that the last practised fire drill was 6 March 2015.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could summarise the basis for their delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information and new guidance were available in recent publications and via their computers. We were told practice staff shared new information during meetings to ensure they were aligned with current guidelines to deliver safe patient care and treatments.

We noted that assessments of patients took place in accordance with NICE guidelines. Where an assessment revealed a more complex diagnosis, patients were referred to associated health care specialists or secondary care services in a timely manner where urgent, often on the same day. We found the GPs and nursing staff were utilising clinical templates within the electronic medical records system to provide thorough and consistent assessments of patient needs. Information we held about the practice showed us that the practice's performance in assessing and treating patients with long term conditions such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease (COPD) were in line with national averages.

The GPs and nurses specialised in a number of clinical areas such as diabetes, heart disease and asthma. This included support from one of the GPs with the dispensary service. This supported the needs of patients who were able to receive appropriate monitoring, along with advice and guidance as to how best to manage their condition and maintain a healthy lifestyle.

The practice computerised patient record system was used to identify those patients whose needs required more regular monitoring. This included those with long-term conditions, complex needs or those patients nearing the end of their lives. The records were coded so that patients needing additional support could easily be identified. We found evidence in meeting minutes of emergency admission audits, and regular reviews of elective and urgent referrals to monitor performance.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scanning documents onto the electronic medical records system, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits, long-term condition management, patient follow-up and review.

The practice showed us two clinical audits that had been undertaken in the last two years. The audit undertaken in 2013 and 2014 was a completed audit. The practice was able to demonstrate the changes since an initial audit which was undertaken to investigate whether the practice could reduce the cost of medicines being wasted at the practice. The re-audit in 2014 followed an initial audit completed in 2013, which showed that when the GPs maintained 28 days prescribing, synchronised prescribing of medicines; if they were ordered together, and identified poor, or total non-compliance, through medicine use review, this reduced drug wastage at the practice. The total cost of medicine wastage for those over 65 years and over was reduced by 62.23%. Overall the surgery made a total saving of 64% following the revision of the practice prescribing behaviours and re-audit.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewarded practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, patients with diabetes had an annual medication review, and the practice met all the minimum standards for

Are services effective?

(for example, treatment is effective)

QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease), physical and/or mental health conditions and chronic kidney disease. This practice was not outside the average range for any QOF (or other national) clinical targets.

There was a protocol for repeat prescribing which was consistent with national guidance. Staff told us they checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Through discussion with the GPs we were assured that the clinicians had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients, their carers and families.

Effective staffing

Practice staffing included medical, nursing, dispensing, managerial and administrative staff. We saw evidence that clinical staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw clinical staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. We reviewed staff training records and saw that all staff were up to date with relevant training courses to support their role. We noted a good skill mix among the doctors, one GP had an additional diploma in ophthalmology and both GPs provided joint injections. The GPs were up to date with their yearly continuing professional development requirements and they had dates this year for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). Newly appointed staff completed a period of induction, which was designed to their role and responsibilities and took into account their skills and previous experience. We looked at staff files, and found appraisals and training records for four members of staff.

During appraisals learning needs had been identified and planned training was documented. Our interviews with staff confirmed the practice was proactive regarding training for staff members and offered relevant courses, for example safeguarding children and adults when they were available.

The practice had dedicated leads for supervising areas such as safeguarding, infection control, palliative care, family planning and female reproductive health. Practice nurses provided services including review of asthma, diabetes, family planning cervical screening, blood test taking, ECGs NHS/senior health checks, blood pressure checks, and dressings. This enabled the GPs to focus on more complex problems and conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs including those with more complex needs. There was a clear procedure for receiving and managing written and electronic communications in relation to a patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the NHS 111 summaries were reviewed by a GP before being actioned on the day they were received.

The practice held bi-monthly multidisciplinary team meetings to discuss patients with complex needs including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses where decisions about care planning were documented in a shared care record. We saw that records were maintained in respect of these meetings, which demonstrated the practice worked collaboratively with other agencies to ensure that patients received appropriate and coordinated care and treatment.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that follow-ups were not missed.

Are services effective?

(for example, treatment is effective)

The practice had implemented proactive case management for all patients on their 2% most vulnerable patients register. The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. This monitoring identified patients for the vulnerable patient register and those most likely to have an unplanned admission to hospital. This work included developing a written and electronic personalised care plan collaboratively with a patient and their carer (if applicable), jointly owned by the patient, carer (if applicable) and named accountable GP. The plans when finalised were signed by the patient and kept at their home to inform visiting healthcare professionals of the agreed care and treatment wishes of the patient, and a copy of the recorded plan was on the patient's records at the practice. The outcome of this work had been to reduce unplanned admissions; the practice reported this had been effective since the plans had been implemented.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. There was also a local central system in place for making secondary care referrals staff told us this was easy to use.

The practice printed out for emergency patients, a copy of their summary medical patient record to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and this was fully operational when we inspected. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was a system for making sure test results and other important communications about patients were dealt with. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, or those receiving end of life care.

The practice had systems to provide staff with the patient information they needed. Staff used an electronic patient medical record to coordinate, document and manage patients' care. All staff were fully trained on the patient medical record system, and were positive about the system's safety and ease of use. The system enabled scanned paper communications, for example letters from the hospital, to be saved in the system for future reference.

The practice maintained patient registers that were identified as vulnerable, had life limiting illnesses, were receiving palliative care and treatments, and patients with learning disabilities. GPs and nurses at the practice worked with Macmillan nurses and other agencies who support people with life limiting illnesses. The practice held bi-monthly palliative care meetings to support and co-ordinate those patients with life limiting illnesses to ensure their care and treatment met their changing needs.

Staff were aware of the importance of patient confidentiality and the need to obtain consent before sharing any information with a third party.

Consent to care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment. GPs and the nurse we spoke with had an understanding of the practice consent procedure and told us they obtained patients verbal consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children and said they obtained parental consent before administering child immunisations and vaccines.

The clinicians 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. Staff we spoke with were aware of the Mental Capacity Act 2005, this related to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests. GPs demonstrated that patients with a learning disability and those with dementia were supported to make decisions through their care plans which were reviewed annually or more frequently if clinically indicated.

Are services effective?

(for example, treatment is effective)

The practice told us they had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint and gave an example in accident and emergency.

Health promotion and prevention

The practice manager met monthly with the local Clinical Commissioning Group to discuss local health issues, implications and share information about the needs of the practice population.

Newly registered patients were offered a medical health check with the nursing staff. The GP was informed of any health concerns detected and these were followed up in a timely way. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led appointments were available for health promotion and disease prevention this included family planning, diabetes, offering smoking cessation advice to smokers, asthma, and cervical screening.

The practice kept a register of all patients with a learning disability and offered them an annual physical health check. The practice had also identified the smoking status of 95.9% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and the practice manager told us they followed up non-attenders to maintain this performance.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Data we looked at before the inspection showed that the practice was performing above average for the area for take up of childhood immunisations. The practice manager told us they followed up non-attenders to maintain this performance.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We gathered views of patients from the practice by looking at the 29 Care Quality Commission comment cards that patients had completed prior to our inspection and spoke in person with seven patients. The response from patients was overwhelmingly positive with all patients reporting that staff at the practice were helpful and good at listening to them. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this experience. The majority of patients said they felt the practice provided consistent and excellent care and treatment.

We reviewed the most recent information available from the national GP patient survey, which was carried out in 2013/2014 showed patients were generally satisfied with how they were treated. The proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care.

Staff were aware of the practice policy for respecting patients' confidentiality, privacy and dignity. Reception staff told us that when patients wished to speak privately in reception, they were offered the opportunity to be seen in a private room. During the inspection we spent time in the practice reception area to give us the opportunity to see and hear how staff interacted with patients. We saw there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

There were signs in the waiting room explaining that patients could request a chaperone during consultations. Patients we spoke with told us they knew that they could have a chaperone during their consultation should they wish it. Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation/treatment room doors were closed during consultations.

The practice staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2013/2014 national GP patient survey showed the practice was about average for the GP involving them in care decisions.

Patients we spoke with on the day of our inspection told us they were listened to and supported by staff. They also told us they had been given sufficient time during consultations to make an informed decisions about the choice of treatment they wished to receive. They told us the GPs were extremely conscientious and spent time explaining information and treatment in relation to their health and care in a way that they could understand. Patient feedback on 27 of the 29 comment cards we received was overwhelmingly positive and many of the 27 patients who responded told us they were happy with their involvement in their care and treatment.

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

Patient/carer support to cope emotionally with care and treatment

The practice had a policy in place to identify and support patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

Are services caring?

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patient wishes in respect of their preferred place to receive end of life care was discussed with doctors other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information about the support was provided to patients who were terminally ill, their carers and families.

Staff told us families who had suffered bereavement were sent a card and called by the GP. An appointment or home visits was arranged as appropriate. There was a variety of written information available to advise patients and direct them locally and nationally to organisations that provide help and support dealing with emotional issues such as bereavement. Notices in the waiting room, and the practice website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of their population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients. The practice told us they accommodated and saw children if they were sick at any time.

The practice utilised an electronic medical records system to record and collect information regarding patients. The practices used a central booking system for making referrals to secondary care which gave patients a choice of location for their appointments.

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

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example those with a learning disability, unemployed, carers, etc.

The practice had access to an online service called the 'Big Word' and NHS telephone interpreting services. The GPs and the practice manager also spoke Hindi, Bengali and Punjabi.

The majority of the premises and services had been adapted to meet the needs of patient with disabilities, for example the front door had a slope and hand rail with a door bell to alert reception staff to help open the door for those patients using a wheelchair or mobility scooter. The practice had one accessible toilet and facilities for baby nappy changing. The practice had two accessible consulting rooms, if patients were unable to manage the single step to the other two consulting rooms.

The practice waiting room and accessible consultation rooms had door openings wide enough for patients with wheelchairs and mobility scooters. This helped to maintain patients' independence.

Access to the service

The main surgery was open between 8am and 6.30pm from Monday to Friday and 8.00am and 7.30pm on Tuesday. Open surgery was held each morning between 9am and 10.30am and booked appointments each evening between 5pm and 6.30pm. There were extended hours on Tuesdays between 6.30pm and 7.30pm. The Goldhanger branch surgery was open between 12.30pm and 1.00pm on Tuesdays and Fridays.

Comprehensive information was available on the practice website about how to make and cancel appointments. This included how to arrange urgent appointments and home visits and how to book appointments online. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service Primecare was provided to patients.

Longer appointments were also available for patients who needed them for those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice's extended opening hours were particularly useful to patients with work and school commitments.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system; there was a poster in the waiting room and information on the practice website.

Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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

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

The practice had a clear statement of purpose to deliver high quality care and promote good outcomes for patients. We found details of their practice values displayed in the waiting areas. The practice statement of purpose included; 'we aim to provide high quality, easily accessible care within a safe family orientated and confidential environment'. We spoke with seven members of staff and they were aware of the practice values.

The practice was proactively concentrating on outcomes in primary care. We saw that the practice recognised where they could improve outcomes for patients and had made changes through listening to staff and patients. For example the practice had not changed the appointment system in line with other practices in the area because the patients at the practice preferred to keep the open surgery option in the morning.

Governance arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. A number of key staff had lead roles, these included infection control, palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. The practice had a strong commitment to making improvements and securing high quality outcomes for patients. The practice used the Quality and Outcomes Framework (QOF) to measure its clinical performance. The QOF data for this practice showed it was performing in line with national standards. We were told that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a lead GP for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported by management and knew who to go to in the practice with any concerns.

The practice manager told us about a local peer group that took part in with neighbouring GP practices. The practice manager told us this group gave the practice the opportunity to measure its service against others and identify areas for improvement.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example medicine wastage audit. The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the practice risk log, assessments were carried out where risks were identified and action plans produced and implemented.

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 self-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

All staff we spoke with told us that the GPs and the practice management team were most approachable. They told us they were encouraged to share new ideas around improving practice services and they felt the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and leave suggestions about how the practice was managed, what worked well and where improvements could be made.

Are services well-led?

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

We saw clearly valuable communication between clinical and non-clinical staff on the day of our inspection. The practice held regular meetings and met more frequently when required to discuss any issues or changes within the practice.

Seeking and acting on feedback from patients, public and staff

The practice had an active Patient Participation Group (PPG) who met quarterly with staff at the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We saw that the practice and the PPG members had developed an action plan to address any issues arising from the patient group meetings. From this plan we saw that the practice was proactive in responding to the needs of patients. For example we saw that the practice had added baby nappy changing facilities to the practice.

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 also told us they felt involved in improving outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook.

Management lead through learning and improvement

The practice had management procedures in place which supported learning and improved performance. During discussions with staff they confirmed they had received annual appraisals and their learning and development needs had been identified and planned. Staff told us the practice strove to learn and to improve patient's experience and deliver high quality patient care. Records showed various clinical audits had been carried out regularly as part of the practice quality improvement process to improve the service and patient care.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which identified role specific training and development needs. These staff members were also supported to achieve their learning objectives, and encouraged to engage in improvement discussions to benefit patients and staff at the practice.