Rushbottom Lane Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Rushbottom Lane Surgery also known as Dr Khan & Partners on 30 August 2017. Overall the practice is rated as good. Previously during a comprehensive inspection on 23 February 2016 this practice was rated as requires improvement for providing safe services.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- All staff had received an appraisal within the last 12 months.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect.
- 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.
- Patients 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 systems to support carers.
- 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 practice was aware of and complied with the requirements of the duty of candour.
- The practice had collaborated with the Castle Point and Rochford Clinical Commissioning Group (CCG) and as part of the Benfleet Consortium of five local GP practices had developed a new approach to

Summary of findings

managing patients with a long term condition. A team consisting of a pharmacist, emergency care practitioner and an advanced nurse practitioner aimed to proactively manage patients at their preferred place of residence, this consisted of managing their ongoing care when needed, both long term and emergency with access to a GP if needed. This project which commenced a few months ago will be evaluated with a view to wider implementation across Castle Point and Rochford CCG.

The areas where the provider should make improvement are:

- Complete the review of the immunisation status of clinical and non clinical staff and ensure a documented process to evidence compliance.
- Undertake a review of practice policies and procedures so they are personalised reflecting local arrangements.
- Continue to monitor the recently introduced systems to monitor the use of blank prescription forms and pads.
- Continue to identify and support carers.

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.
- Medicines were checked stored and managed appropriately. Blank prescription forms were tracked and stored securely through a recently introduced monitoring system.
- At the time of our inspection we noted the record of immunisation status for applicable clinical and non clinical staff as recommended by the Health and Safety at Work Act (HSWA) 1974, was incomplete. After our inspection the practice confirmed that all applicable clinical staff had current vaccination for hepatitis B.
- 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 90%, compared to the CCG average of 86% and the national average of 90%.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.

Summary of findings

- 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.

- Data from the most recent national GP patient survey published July 2017 showed patients rated the practice higher than others for several aspects of care. Patients were treated with compassion, dignity and respect and were involved in decisions about their care and treatment.
- Patients we spoke with and the two comment cards we received 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 and a nominated carer's champion helped ensure that the various services available to support 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?

Good

The practice is rated as good 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 patient's satisfaction with how they could access care and treatment. For example, 92% 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%.

Summary of findings

- 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.

Are services well-led?

Good

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

- The practice had aims, key objectives and plans to deliver high quality care and promote good outcomes for patients. Staff were knowledgeable about these 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. However some policies were generic and had not been personalised to reflect practice specific arrangements.
- 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 and nurses who were skilled in specialist areas used their expertise to offer additional services to patients. For example diabetes and asthma care.

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 including through home visits if needed.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- The practice had identified patients at high risk of admissions to hospital (patients with multiple complex needs, and involving multiple agencies) and worked with community services in planning support. 92% of these patients had a care plan created or reviewed in the past 12 months and their care plans were available to other professionals through the shared electronic records system.
- 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 advanced nurse practitioners visited housebound patients to undertake dementia screening and other monitoring such as blood pressure monitoring.
- The practice supported patients registered with the practice who lived in local care homes.

People with long term conditions

Good

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

Summary of findings

- GPs supported by nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- There was a recall system in place to coordinate long term condition management.
- Performance for diabetes related indicators was comparable to the local and national averages. The practice achieved 83% of available points, with 7% exception reporting, compared to the CCG average of 82%.
- The practice had collaborated with the Castle Point and Rochford Clinical Commissioning Group (CCG) and as part of the Benfleet Consortium of five local GP practices and developed a new approach to managing patients with a long term condition. A team consisting of a pharmacist, emergency care practitioner and an advanced nurse practitioner aimed to proactively manage patients at their preferred place of residence, this consisted of managing their ongoing care when needed, both long term and emergency needs with access to a GP if needed.
- The practice held a register of pre-diabetic patients who status was monitored annually by a blood test and followed up if abnormal.
- The practice provided on site pulse oximetry (measurement of the oxygen level in blood and the heart rate), 24 hour blood pressure monitoring, 24 hour electrocardiogram (ECG), routine and urgent ECGs and spirometry.
- The practice offered annual structured chronic kidney disease clinics.
- 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.
- 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.
- The practice identified at an early stage patients who may need palliative care as they were approaching the end of life. It involved patients in planning and making decisions about their care, including their end of life care. Palliative care was

coordinated with the palliative care nurse and district nurse through monthly palliative care Gold Standard Framework meetings. Information was passed to the out-of-hours team for continuity of care on a weekly basis.

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 85%, compared to the CCG average of 86% and the national average of 81%.
- Teenage girls registered with the practice were offered immunisation against the human papilloma virus (HPV) which offered protection against cervical cancer.
- There was a dedicated young person's notice board in reception area which contained sexual health information including on how to access the local sexual health clinics.
- The practice offered family planning including the management of intrauterine system and related screening such as chlamydia screening.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- 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 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).

Summary of findings

- 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.
- This population were given priority appointments focussed on early morning and late afternoon. On Thursday mornings the practice was open from 7am. On Monday evenings the practice was open until 7.30pm.
- On Saturday, Sunday and Bank Holidays access to a GP was available from 10am until 3pm and in the evening from 7pm until 9pm for pre-bookable appointments. This additional service was provided by the local GP healthcare alliance and patients were advised which practice to attend when they booked the appointment.
- The practice provided a ring back service by a duty GP or a nurse at the patient's request where appropriate which supported patients who were unable to attend the practice during normal hours.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this age group.
- 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.

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 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. Palliative care was coordinated with the palliative care nurse and district nurse through monthly palliative care Gold Standard Framework meetings. Information was passed to the out-of-hours team for continuity of care on a weekly basis
- The practice offered longer appointments for patients with a learning disability.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients including when they move out of area so an appropriate hand-over can be given to the new practice.
- 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's computer system alerted GPs if a patient was also a carer. The practice had identified 110 patients as carers (approximately 1% of the practice list). The practice had identified a carer's champion who provided information and directed carers to the various avenues of support available to them.

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 70%.
- 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 88% compared with the CCG average of 79%.
- The practice regularly worked with multi-disciplinary teams including the community dementia nursing team, district nurses, long term conditions team, care coordination team and social services 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.

Summary of findings

- The practice had information available for patients experiencing poor mental health about how they could access a number of support groups and voluntary organisations.
- 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

Areas for improvement

Action the service SHOULD take to improve

- Complete the review of the immunisation status of clinical and non clinical staff and ensure a documented process to evidence compliance.
- Undertake a review of practice policies and procedures so they are personalised reflecting local arrangements.
- Continue to monitor the recently introduced systems to monitor the use of blank prescription forms and pads.
- Continue to identify and support carers.

Rushbottom Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Rushbottom Lane Surgery

Rushbottom Lane Surgery also known as Dr Khan & Partners situated at 91 Rushbottom Lane, Benfleet, Essex is a GP practice which provides primary medical care for approximately 12,034 patients living in Benfleet and the surrounding areas.

Rushbottom Lane Surgery 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 six GPs partners and two other GPs (four males and four females). There are two advanced nurse practitioners and three practice nurses who are supported by a health care assistant and an associate practitioner. There are two practice managers who are supported by a deputy and a team of administrative and reception staff. There is a pharmacist employed by the practice. The local NHS trust provides health visiting and community nursing services to patients at this practice.

The practice provides training to doctors studying to become GPs. Additionally the practice facilitates the training of nurses, managers, administrative staff and work experience students. The practice operates out of a two storey building. Patient care is provided on both floors with lift access available to the upper floor. There is a car park outside the surgery with adequate disabled parking available.

The practice is open between 8am until 6.30pm Monday to Friday. On Monday evenings the practice is open until 7.30pm. On Thursday mornings the practice is open from 7am. On Saturday Sunday and Bank Holidays access to a GP is available from 10am until 3pm and in the evening from 7pm until 9pm. The Saturday Sunday and Bank Holidays service is provided by the local GP healthcare alliance and patients are advised which practice to attend when they booked the appointment.

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.

Detailed findings

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 visit on 30 August 2017. During our inspection we:

- 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 reception 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 two 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 parent of a child following a prescription incident with an apology explanations and reassurance that prescribers had been reminded of the policy with related staff training to avoid a repetition.
- We saw that significant events were discussed, reviewed and action points noted at least every month. Learning points were shared through clinical and administrative forums as appropriate. Individual actions were taken forward by the practice manager or a lead GP with whole practice learning disseminated through monthly time to learn (TTL) 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 affected clinical staff were aware of the correct procedure to make patient referrals to acute care facilities.
- 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 type 2 diabetes. We found that the practice had acted on the recommendations and ensured patients were prescribed this medicine with caution.

Overview of safety systems and processes

The practice had clearly 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 on the desktop 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 the weekly practice clinical meetings. 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 a young person with concerns for their personal safety we saw that the practice had liaised with social services and other relevant agencies 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 three) 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.

Good

Are services safe?

- 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.
- A GP and the nurse manager were joint infection prevention and control (IPC) leads who liaised with the local infection prevention teams to keep up to date with best practice.
- Staff had received up to date IPC training. Annual infection control audits were undertaken and action was taken to address any improvements identified as a result.
- A spillage kit was available to deal with spillage of body fluids and staff knew where the kit was kept. However we did not see any guidance within the IPC policy on dealing with spillages. The practice manager after our inspection sent us a copy of the relevant guidance on dealing with spillages.
- At the time of our inspection we noted the record of immunisation status for applicable clinical and non clinical staff as recommended by the Health and Safety at Work Act (HSWA) 1974, was incomplete. The practice manager told us that they were reviewing the status as a matter of priority. After our inspection the practice confirmed that all applicable clinical staff had current vaccination for hepatitis B.

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. We ran searches and checked patients that received a range of high risk medicines and found that these patients were being appropriately monitored.
- The practice carried out regular medicines audits, independently and with the support of the Castle Point and Rochford CCG medicines management team and an in house pharmacist to ensure prescribing was in line with best practice guidelines for safe prescribing. For example the practice had worked with the CCG to review antibiotic prescribing patterns of GPs and found that the prescription of this medicine was in accordance with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were recently introduced 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.
- The practice held controlled drugs (medicines that require extra checks and special storage because of their potential for misuse), and we saw evidence that there were procedures in place to manage them safely. There were also arrangements for the destruction of controlled drugs.

We reviewed five 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. However we found this policy generic and had not been personalised to the practice.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice.
- 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a 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.
- 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. A copy of the plan was held off site by the practice manager.

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 every six weeks and discussions were led by a GP. For example we saw that a lead GP had updated all clinical staff with the guidelines related to a particular diagnostic test/ investigation. This ensured all patients who may require such an investigation were referred and followed up in accordance with best practice guidelines.
- 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 96% of the total number of points available with 4.2% exception reporting compared with the clinical commissioning group (CCG) average of 91% with 4.2% exception reporting and national average of 95% with 5.7% 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).

Data from 2015/16 showed:

- Performance for diabetes related indicators was comparable to the local and national averages. The practice achieved 83% of available points, with 7% exception reporting, compared to the CCG average of 82%, with 8% exception reporting, and the national average of 90%, with 12% exception reporting.

  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 74%, compared to the CCG average of 74% and the national average of 78%. Exception reporting for this indicator was 5% 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 97% of available points, with 11% 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 88% where the CCG average was 79% and the national average was 89%. Exception reporting for this indicator was 7% 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 100% of available points, with 12% exception reporting, compared to the CCG average of 90%, with 13% 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 70% where the CCG average was 75% and the national average was 84%. Exception reporting for this indicator was 4% compared to a CCG and national average of 7%.

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 year; 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 patients that received a particular type of medicine to treat high blood pressure, the practice had amended its systems so all new patients received the required blood tests within two weeks of commencement of this medicine.

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 chronic kidney disease (CKD) 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. Staff had access to and made use of e-learning training modules and in-house training as well as external training events, seminars and conferences.
- Two trainee GPs (called GP registrars) we spoke with told us that they were well supported by the GPs other clinical staff and by the whole practice team.
- The practice was part of the CCGs parachute scheme whereby GPs from Rushbottom Lane Surgery supported a failing practice to achieve the required standards of care.

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 and held a register of patients with such needs. Meetings took place with other primary health care professionals at least twice monthly when care needs were routinely reviewed and updated as needed.
- 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.
- Written 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.
- There were on site health promotion programmes such as smoking and alcohol cessation, and weight matters.
- Patients could access the improving access to psychological therapies (IAPT) service hosted by the local CCG through a GP referral.
- Young people aged 18 and over had access to the Befriending Scheme hosted by the Castle Point & Rochford CCG which helped them to improve their feeling of wellbeing and help integrate them back into the community.
- 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.
- The practice had a system to recall patients for further monitoring or treatments, for example pre-diabetic patients and patients referred for endoscopy.
- The practice provided on site dermatology clinic.
- The practice's uptake for the cervical screening programme was 85%, 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:

- 74% 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 95% 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 84% and 98% (national averages ranged between 88% and 94%) 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 undertook 354 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

During our inspection we observed that 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.

The two patient Care Quality Commission comment cards we received were positive about the service experienced. The two patients noted that their experience of the care received was positive and the practice staff had been helpful friendly caring and treated them with dignity and respect.

We spoke with five patients including two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The two comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the CCG average of 86% and the national average of 89%.
- 92% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 86%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 86%.
- 97% of patients said the nurse was good at listening to them compared to the CCG average of 94% and the national average of 91%.
- 97% of patients said the nurse gave them enough time compared to the CCG average of 94% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 99% and the national average of 97%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 91% of patients said they found the receptionists at the practice helpful compared with the CCG and the national average of 87%.

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.

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 in line with local and national averages. For example:

- 92% 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%.

Good

Are services caring?

- 89% 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%.
- 97% 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%.
- 94% 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 leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 110 patients as carers (approximately 0.9% of the practice list). The practice had identified a carer's champion who provided information and directed carers to the various avenues of support available to them. The practice was aware that there was potential to increase the number of carers based on its practice list size and were actively working towards this aim. 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 other vaccinations as appropriate.

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

Good

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.
- On Monday evenings the practice was open until 7.30pm. On Thursday mornings the practice was open from 7am.
- The practice provided a ring back service by a duty GP or a nurse at the patient's request where appropriate.
- The practice offered alternative practitioner sessions for example with an advanced nurse practitioner.
- 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 including through home visits if needed.
- The advanced nurse practitioners visited housebound patients to undertake dementia screening and other monitoring such as blood pressure monitoring.
- The practice supported patients registered with the practice who lived in local care homes.
- 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) and asthma.
- The practice held a register of pre-diabetic patients who status was monitored annually by a blood test and followed up if abnormal.
- The practice provided on site pulse oximetry (measurement of the oxygen level in blood and the heart rate), 24 hour blood pressure monitoring, 24 hour electrocardiogram (ECG), routine and urgent ECGs and spirometry avoiding the need for the patient to visit an acute facility for these tests.
- There was a recall system in place to coordinate long term condition management.
- The practice offered annual structured chronic kidney disease clinics.
- 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 offered family planning including the insertion and removal of intrauterine contraceptive devices. The practice also offered chlamydia screening.
- Patients were able to receive travel vaccinations available on the NHS and for yellow fever.
- 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 between 8am until 6.30pm Monday to Friday. On Monday evenings the practice was open until 7.30pm. On Thursday mornings the practice was open from 7am. On Saturday Sunday and Bank Holidays access to a GP was available from 10am until 3pm and in the evening from 7pm until 9pm for pre bookable appointments. The Saturday Sunday and Bank Holidays service was provided by the local GP healthcare alliance and patients were advised which practice to attend when they booked the appointment. Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 77% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) and the national average of 76%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 64% of patients said they could get through easily to the practice by phone compared with the clinical commissioning group (CCG) average of 62% and the national average of 71%.
- 92% 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%.
- 93% of patients said their last appointment was convenient compared with the clinical commissioning group (CCG) average of 85% and the national average of 81%.
- 82% of patients described their experience of making an appointment as good compared with the CCG and national average of 73%.
- 79% 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%.

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 38 (of which 33 were verbal) 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 about a prescription, we saw that the practice had responded to the complainant giving an explanation of the practice prescribing policy. We also saw that the practice had offered an apology.

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 was committed to delivering high quality patient centred care to all its patients.

- They aimed to provide healthcare which was available to the whole population in partnership with patients and health professionals which ensured mutual respect, holistic care and continuous learning and training.
- By developing and maintaining a happy environment which was responsive to people's needs and expectations and which reflected whenever possible the latest advances in Primary Health Care the practice aspired to provide a rewarding workplace that supported a healthy work life balance for staff.

The aims were supported by the following broad objectives:

- Develop and improve patient care pathways.
- Provide alternatives to hospital based specialist treatment.
- Provide timely assessment of patients.
- Reduce the secondary care waiting lists.
- Help manage patients in primary care through specialist advice and feedback.
- Ensure excellent communication with referring doctors, patients and the community clinic.

The practice had a three year forward business plan to ensure it remained accessible and cost effective. Examples included practice team development, patient partnerships, practice development and collaborative working.

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 staffing structure and staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example a GP led on prescribing and safeguarding and an advanced nurse practitioner led on asthma and COPD.
- Practice specific policies were implemented and were available to all staff. However we noted that some practice specific policies were generic and had not been personalised to reflect local arrangements. For example the health and safety policy and the recruitment policy.
- 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.

Are services well-led?

Good

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

- Staff told us the practice held regular team meetings 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.
- Two GPs from the practice were on the governing body of the NHS Castle Point and Rochford CCG and had lead roles. For example one GP led on integration and another led on the NHS EU (European Union) GP pilot CCG wide.
- The practice had collaborated with the Castle Point and Rochford Clinical Commissioning Group (CCG) and as part of the Benfleet Consortium of five local GP practices and developed a new approach to managing patients with a long term condition. A team consisting of a pharmacist, emergency care practitioner and an advanced nurse practitioner aimed to proactively manage patients at their preferred place of residence, this consisted of managing their ongoing care when needed, both long term and emergency needs with access to a GP if needed. This project which commenced a few months ago will be evaluated with a view to wider implementation across Castle Point and Rochford CCG.
- The practice proactively succession planned to ensure sustained staffing. For example a GP had attended a local school and made a career talk to six form students on becoming a GP.
- The practice was also a participant in the NHS EU GP pilot whereby the practice hosted a GP from the European Union (EU) with a view to training them to become a GP in the UK.

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 from:

- patients through the patient participation group (PPG) which was hosted jointly with the other practice that shared the building. We spoke with two members of the PPG who told us that they had worked with the practice on several initiatives. For example we noted that the PPG had worked with the practice in resolving the timeliness of the issuing of repeat prescriptions. They had also installed a suggestion box which had resulted in the provision of a coffee dispenser, television screen with health and other information and a drinking water dispenser. They had also made available to the wider practice population more information about the advanced nurse practitioners and the scope of their work and consultations. Two PPG members attended meetings coordinated by the CCG, the clinical reference group, and following a recent meeting had agreed to contribute to a CCG wide newsletter with practice specific information.
- 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. We saw the practice encouraged staff to upskill so they could take emerging opportunities within the practice. For example:

- The practice currently supported three advanced nurse practitioners (ANP) through the masters programme in advanced practice.
- Developed student nurse induction packs which were now being used across the CCG.
- As a nurse training practice it provided the only two sign off mentors in Castle Point & Rochford CCG area thereby encouraging local training of nurses.
- The practice was part of the NHS England productive general practice quick start scheme which aimed to spread awareness of innovative practice that released time for care. Through this scheme it was estimated that most practices could expect to release about ten per cent of GP time. The pilot has been ongoing since December 2016.