Clayhill Medical Practice

Quality Report

Vange Health Centre,
Southview Road,
Vange,
Basildon,
Essex
SS16 4HD
Tel: 01268 288664
Website: www.ClayhillMedicalPractice.nhs.uk

Date of inspection visit: 13/01/2015
Date of publication: 30/04/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Detailed findings from this inspection

Our inspection team 10

Background to Clayhill Medical Practice 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Clayhill Medical Practice on 13 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people 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 infection control audits undertaken on a regular quarterly basis.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients 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.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice held a successful health awareness open day on a Saturday in October 2014, which was well

Summary of findings

received by partner agencies and people in the local community who had attended. This event offered advice and information, and raised the profile of the practice in the local community

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and we saw evidence from audits it was used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and had regular access within the practice building on a daily basis.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received positive remarks on our comment cards about the care patients experienced at the practice, and the patients we spoke with during the inspection confirmed this.

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 NHS England Area Team and the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. CCG's a group of patients registered with a practice who work with the practice to improve services and the quality of care. Patients said they could make an appointment with a named GP

Summary of findings

and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff during regular meetings and other stakeholders.

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 their responsibilities 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. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings e-learning and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Other examples of support for older people included blood taking clinics, blood pressure monitoring, annual assessment and medication review.

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 unplanned hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Examples of support for people with long-term conditions included blood tests, blood pressure monitoring, electro cardiogram (ECG) readings, asthma, chronic obstructive pulmonary disease (COPD), and diabetes weekly clinics on a Friday. ECG is equipment to record electrical activity of the heart to detect abnormal rhythms and the cause of chest pain. COPD is severe shortness of breath caused by chronic bronchitis, emphysema, or both.

Families, children and young people

Good

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

Summary of findings

people included clinics for mothers and babies at six to eight weeks old, baby check-ups and mother post-natal check-ups. There were baby immunisations, and advice on family planning and contraceptives. Clinicians at the practice could liaise with the community midwives when a patient was pregnant as they worked from the same building. They held quarterly meetings attended by health visitors that could update them with any changes within their department or any concerns regarding patients.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Examples of support for working-age people (including those recently retired and students) were extended hours on alternate Wednesday and Thursday evenings between 6.30pm and 9.30pm with the GP or practice nurse. Meningococcal (MENC) fresher vaccination for students, and NHS Health checks. The practice were pleased to have patients from this group population group sitting on their Patient Participation Group to give insight into what they thought of the services provided by the practice.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 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. The practice provided appointments with interpreters for patients when requested whose first language was not English. Staff knew how to recognise signs of abuse in vulnerable adults and children. 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.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health received annual physical health checks. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

All seven of the patients we spoke with on the day of inspection told us they were more than satisfied with the service they experienced at the practice. Patients also told us they were able to get appointments when they needed them.

A community healthcare professional told us they received quite a few referrals of patients from the practice, and that they were always appropriate as they required extra support from their specialist team. They also told us the referrals they received always gave sufficient information regarding the patient's treatment schedule and interventions given at the practice. We were also told by the community healthcare professional that they had a good relationship with the practice manager and have found her to be most accommodating. They told us that they were allowed space at the practice to see patients in their practice environment and the practice staff checked with patients before they passed on their details to ensure they were happy for the community health team to have the information. The community healthcare professional also told us that they felt the GPs at the practice responded well to their advice and appeared to respect their knowledge.

We also spoke with a healthcare professional working at the practice on the day of inspection providing counselling support to patients. They told us the GPs referrals were appropriate, and they understood the criteria for patient referrals. They also told us they felt the practice team was really professional and nothing was too much bother to ensure the well-being of their patients.

Clayhill Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector; they were accompanied by a GP specialist advisor.

Background to Clayhill Medical Practice

The practice is located at Vange Health Centre, Southview Road, Vange, Basildon, Essex. The practice provides services to approximately 6600 patients living in the local area and holds a General Medical Services (GMS) contract.

Clayhill Medical Practice has two GP partners; one male and one female. The GPs are supported by two practice nurses, a healthcare assistant, a practice manager, an administrator, secretaries and reception staff. There is also access to health visitors, community midwives and a counsellor. The names of these healthcare professionals appear in the practice leaflet and on the practice website to allow patients to request care from the same person for consistency.

The practice is open Monday to Friday from 8.30am to 6.30pm. Consultation appointments were available Monday to Friday from 9am until 1pm and then from 3.30pm until 6:20pm. The practice is open for extended hours on alternate Wednesday and Thursday evenings for pre-booked appointments from 6:30pm until 7.30pm. Home visits are available as required based upon need.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings and weekends. During these times GP services are provided by South Essex Emergency Doctor Service (SEEDS), an out-of-hours advice, emergency and non-emergency treatment service. Details of how to access SEEDS is available within the practice on the practice website and on the practice leaflet.

Why we carried out this inspection

We carried out a comprehensive inspection of Clayhill Medical Practice 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.

This provider had not been inspected before and that was why we included them.

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

How we carried out this inspection

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

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

Detailed findings

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

The population groups are:

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

Before visiting, we reviewed a range of information that we hold about Clayhill Medical Practice and asked other organisations and healthcare professionals to share what they knew. We carried out an announced comprehensive inspection visit on 13 January 2015. During our visit we spoke with the GPs, practice nurses, the practice manager, administrative and reception staff. We also spoke with seven patients who used the service. We reviewed 25 comment cards where patients and members of the public shared their views and experiences of the service. We also spoke with healthcare professionals associated with the practice both prior to our visit and on the day of inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with was aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the last year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were not a standing item on the practice monthly meeting agendas but if the practice had a significant event or complaint to review they were added as needed. There was evidence that the practice had learnt from significant events and complaints. It was also evident that the findings were shared with relevant staff including receptionists, administrators, and nursing staff, who knew how to raise an issue for consideration at meetings and felt encouraged to do so.

The practice manager showed us the system used to manage and monitor incidents. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example the introduction of a chart for staff to use as a reference guide to ensure they used the correct tube and top when sending samples to the lab. Staff were also reminded to speak to a phlebotomist at the hospital to check if they were still in any doubt. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. We saw evidence of the system log used to collate the alerts with the action taken, who received it, the relevant staff member that actioned it, the impact for the practice, and the outcome.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training for safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There was a chaperone policy, which was visible on the waiting room noticeboard. (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 advised patients they were are entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. All nursing staff had been trained to be a chaperone.

Medicines management

Good

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures to ensure that they remained effective and fit for use. The policy described the action to take in the event of a potential fridge failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The GP specialist advisor in the inspection team checked two anonymised patient records which confirmed that a suitable procedure was being followed to ensure patient safety.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be 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 that confirmed these findings.

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. Staff received induction training about infection control specific to their role and annual updates.

We saw the practice infection control lead had carried out quarterly audits in line with the requirements of the practice policy. Audits for minor surgery had been conducted and did not reveal any infection issues.

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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We noted that all equipment had been tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place.

Staffing and recruitment

Records we looked at showed that appropriate recruitment checks had been undertaken prior to staff taking up employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff 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. 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.

Good

Are services safe?

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were 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

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. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within practice team meetings. For example, the practice manager had shared the recent findings from a trip/fire hazard with the practice team.

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. The notes of the practice meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

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 (allergic reaction) and hypoglycaemia (low blood sugar). Processes were also 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 mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, the location of the fuse box if there was a failure of electricity.

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 they practised regular fire drills and were fire wardens.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), Clinical Knowledge Summary (CKS) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with these guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease, mental health and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for accident and emergency attendances, referral rates and emergency admissions which showed improvement over the last year. The practice had also completed a review of patient records attending for minor surgery. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

GPs we spoke with used national standards for the referral for example patients with suspected cancers to be referred and seen within two weeks. We saw evidence of Clinical Commissioning Group (CCG) meetings where reviews of elective and urgent referrals were made, and that improvements to practice were shared with practice staff.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

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, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been undertaken in the last two years, one of these was a completed audit where the practice was able to demonstrate the improvements changes resulting since the initial audit. We saw evidence of an improvement in the correct recording of consent following one completed audit. We also saw an audit undertaken to understand the reason patients who received a contraceptive implant came back for early removal; to look for trends to ensure they had received the correct counselling prior to treatment. This audit had not yet been completed through a complete audit cycle.

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 rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, an audit regarding the prescribing of anti-epileptic drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. The GPs maintained records showing how they had evaluated the service and documented the success of any changes.

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

Good

Are services effective?

(for example, treatment is effective)

review, and showed above average national percentages against targets and met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease) This practice was not an outlier for any QOF or other national clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing, in line with this; staff regularly 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 computerised record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs 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 and their families. As a consequence of staff training and better understanding of the needs of patients with life limiting illnesses.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example accident and emergency attendances and in-patient spells in hospital.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending training courses such as annual basic life support. We noted a good skill mix among the doctors and the GPs were up to date with their yearly continuing professional development requirements. One GP was due for re-validation later in the year and other GP the following year. (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).

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

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and long-term conditions management. Those seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We checked the records and found no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

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.

Good

Are services effective?

(for example, treatment is effective)

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, palliative care nurses and decisions about care planning were documented in a shared care record.

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. Electronic systems were also in place for making referrals, and the practice made through the Choose and Book system. (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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic 'Summary Care Record' and planned to have this fully operational by April 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used the practice electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.)

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases but the correct recording system was not always used and further audit was on-going to improve this.

Health promotion and prevention

The practice had met with the team from the local CCG to discuss the implications and share information about the needs of the practice population.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic sexual health checks such as chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that of patients in this age group were actively called in for these assessments and took up the offer of the health check. We were told patients were followed up if they had risk factors for disease identified at a health check and scheduled for further investigations.

Good

Are services effective?

(for example, treatment is effective)

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and offered an annual physical health check, with 100% uptake. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months had increased at the practice. 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's performance for cervical smear uptake was similar to others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Performance for national chlamydia, mammography and bowel cancer screening in the area were all similar for the CCG, and a similar mechanism of following up patients who did not attend was also used for these screening programmes.

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 similar for the CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice held a successful health awareness open day on a Saturday in October 2014. Representatives from a range of organisations attended and reported to us how positive this event had been. For example services represented were: learning disabilities, heart failure, nutrition and dietetics, child and health visitors, vitality, diabetics, Essex carers, 'Boots' pharmacy Basildon, mental health (MIND), and stoma nurses. Various services brought along free gifts, information, and provided tests, and free advice. The feedback from patients, staff and the organisations involved in the days was most encouraging and the practice plan to make this an annual event. We were told this had been a really well received community event and had raised the practice profile for the local population. Patients from the Patient Participation Group told us that the GPs had made themselves accessible on the day, and that people attending had commented on the excellent opportunities to network with both the GPs and the other organisations involved.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey 2013 - 2014 and a survey of 150 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the patients rated the practice as good. The practice was also rated as good or very good at involving them in decisions about their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 25 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with seven patients on the day of our inspection. All told us they were more than satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We noted in the national patient survey 2013-2014 for the practice, patients had rated confidentiality better than average at the practice.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff during a meeting. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place within staff meeting minutes that showed this has been discussed.

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

Care planning and involvement in decisions about care and treatment

The national GP patient survey 2013 - 2014 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. The results from the PPG satisfaction survey showed that 72% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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.

The practice had implemented proactive case management for all patients on their 2% most vulnerable patients register. This work included developing collaboratively with a patient and their carer (if applicable) a written and electronic personalised care plan, jointly owned by the patient, carer (if applicable) and named accountable GP. 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

Good

Are services caring?

patients for the vulnerable patient register and those most likely to have an unplanned admission to hospital. The plans when finalised were signed by the person and kept at their home to inform visiting healthcare professionals of the care and treatment agreed wishes of the patient, and recorded on their records at the practice. The outcome of this work has been to reduce unplanned admissions; the practice has reported a reduction since the plans have been implemented.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were positive about the emotional support provided by the practice. For example, they highlighted that staff responded compassionately when they needed help and provided support when required. We also spoke with a healthcare professional working at the practice on the day of inspection providing counselling support to patients. They told us the GPs' referrals were appropriate, and they understood the criteria for patient referrals. They also told us they felt the practice team was really professional and nothing was too much bother to ensure the well-being of their patients.

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) the practice produced information for the website and a leaflet informing patients about home visits, telephone appointments and extended appointment slots. The information told patients when these appointments were available, about the appointment and when to request these.

An example of responding to patients' needs, for patients experiencing poor mental health (including those with dementia) the practice has appointed a GP mental health lead at the practice. The lead had close ties with a local facility where they saw patients with mental health issues on a regular basis.

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, and those patients who are carers.

The practice had access to online and telephone translation services and a GP who spoke two languages.

The practice provided equality and diversity training through e-learning. Staff we spoke with showed us certificates to confirm that they had completed the equality and diversity training in the last 12 months.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was located in a purpose built property suitable for the provision of healthcare services; that was Equality Act compliant. The practice had a ramp at the entrance for wheelchair users and electronic door opening. The front entrance ensured good access for disabled patients, prams and wheelchair users. The practice had wide corridors for easy access to the treatment and consultation rooms patients with mobility aids. This made movement around the practice easy and helped to maintain patients' independence. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a small transient population of non-English speaking patients though it could cater for different languages through translation services.

Access to the service

The practice was open Monday to Friday from 8.30am to 6.30pm. Consultation appointments were available Monday to Friday from 9am until 1.30pm and then from 4pm until 6:30pm. The practice was open for extended opening on alternate Wednesday and Thursday evenings for pre-booked appointments from 6:30pm until 7:45pm. Home visits are available as required based upon need.

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

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

Patients were generally 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.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 on the practice website and in the practice leaflet. 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 complaints received in the last 12 months and found these had been satisfactorily handled, and dealt with in a timely way, that showed openness and transparency when dealing with the compliant.

The practice reviewed complaints annually to detect themes or trends which were discussed at the GP partners meetings. We saw no themes had been identified however, lessons had been learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's statement of purpose. The practice vision and values included; provide and maintain the highest standard of care for patients with adequate training given to staff in order to promote and maintain this standard of care.

We spoke with four members of staff and they all knew and understood the values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 12 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at team meetings and the actions taken to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example consent audit and contraceptive implant audit.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues for example trip and fire hazards. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. An example of actions carried out was to ensure the screen in the reception was turned off each day as it gets very hot and could be a potential fire hazard.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

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

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that the team had time to learn half day opportunities four times a year.

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient participation group (PPG) patient surveys, and complaints received. We looked at the results of the annual patient survey and saw the practice had produced information for the website and a leaflet informing patients

Are services well-led?

Good

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

about home visits, telephone appointments and extended appointment slots. The information told patients when these appointments were available, about the appointment and when to request these.

The practice had an active patient participation group (PPG) which has steadily increased in size. The PPG included representatives from various population groups; including older people and working age people. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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. Staff told us they felt involved and engaged in the practice to improve 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

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had time to learn half days for training monthly.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example cardboard had been left in the wrong area within the practice, the risk had been identified, rated, responsibility for removal assigned, staff notified and requested to be vigilant this issue was not repeated.