Oakdin Surgery

Quality Report

The Surgery
Laindon Road
Billericay
Essex
CM12 9LD
Tel: 01277 631030
Website: www.oakdinsurgery.co.uk

Date of inspection visit: 4 February 2015
Date of publication: 08/05/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Oakdin Surgery on 04 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for each of the population groups.

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 and addressed.
- 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.
- 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.
- Non clinical staff encouraged and supported patients to take responsibility for their own health and the management of their medical condition

However there were areas of practice where the provider should make improvements.

Action the provider should take to improve:

- Carry out appropriate recruitment checks to ensure staff members' suitability for their role and risks are assessed for those who undertake chaperone duties.

Summary of findings

- Conduct an infection and prevention control audit to identify potential risks
- Maintain emergency oxygen

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. 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 at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from various sources such as the National Patient Survey, the practice GP survey and comments registered on the NHS Choices website showed that patients rated the practice highly. This was confirmed in the comment cards we reviewed and the conversation we had with patients and their families. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. 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 suitable facilities and was well equipped to treat patients and meet their needs.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear 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. The practice proactively sought and listened to feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings 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 provider was rated as good overall and this includes this population group. The provider was rated as good for safe, effective, caring, well led and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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. It was responsive to the needs of older people, and offered home visits and 'on the day' appointments.

People with long term conditions

Good

The provider was rated as good overall and this includes this population group. The provider was rated as good for safe, effective, caring, well led and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The GP maintained responsibility for leading in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The provider was rated as good overall and this includes this population group.

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 high for all standard childhood immunisations when compared to similar practices within their Clinical Commissioning Group. 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 health visitors.

Summary of findings

Working age people (including those recently retired and students)

Good

The provider was rated as good overall and this includes this population group.

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 provided continuity of care. For example, students were encouraged to register as temporary patients during holiday periods enabling them to access health care.

People whose circumstances may make them vulnerable

Good

The provider was rated as good overall and this includes this population group.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for all their patients with a learning disability and offered longer appointments to support them and facilitate communication.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. and the practice signposted them to various support groups and voluntary organisations. 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.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good overall and this includes this population group.

People experiencing poor mental health had received an annual physical health check and were offered flexibility with their appointments to best suit their individual needs. The practice regularly worked with multi-disciplinary teams including acute mental health care services, coordinating services where their patients had a need. The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We provided the practice with comment cards ahead of our inspection and invited patients to complete them so we could capture their experiences of the service. We reviewed 40 cards that had been completed and all were overwhelmingly positive about the highly responsive and personalised service they received from the practice team. Patients we spoke with on the day found the reception staff attentive, polite and supportive and the GP and nursing team kind, patient and knowledgeable, always having time to listen and meet their individual needs. These findings were reflected in the National Patient Survey 2014 and the comments on NHS choices website, which showed that patients experienced a high level of satisfaction with access to the service and the care and treatment they received.

Areas for improvement

Action the service SHOULD take to improve

- Carry out appropriate recruitment checks to ensure staff members' suitability for their role and risks are assessed for those who undertake chaperone duties.
- Conduct an infection and prevention control audit to identify potential risks
- Maintain emergency oxygen

Oakdin Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP.

Background to Oakdin Surgery

Oakdin Surgery has a patient population of approximately 900. The practice has one male GP and a small nursing and administrative team. The practice holds a General Medical Service contract. This is the type of contract the practice holds with NHS England to provide medical care to patients.

The CQC intelligent monitoring placed the practice in band three. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The provider registration is currently under review to reflect the full range of services provided. The practice does not have a website for their GP service but maintains a website for their private surgical procedures, such as conducting vasectomies and reversal operations.

The practice has opted out of providing out-of-hours services to their own patients. The services are provides by South East Essex Doctors Service (SEEDS). Information is provided to patients in their practice leaflet and patients are actively encouraged to call them prior to attending accident and emergency services.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- 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 the practice and asked other organisations to share what they knew. We provided the practice with comment cards ahead of our inspection and invited patients to complete them so we could capture their experiences of the service. We carried out an announced visit on 04 February 2015. During our inspection we spoke with a range of staff, GP, practice nurse, practice manager and receptionists and spoke with patients who used the service.

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, the practice manager reviewed and maintained electronic and manual files of all alerts received, such as those sent by the Medicine and Health Regulatory Agency , CQC, NHS England and Health and Safety Executive. Recently they received an alert relating to window blind safety measures and had reviewed their arrangements to ensure patient safety. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the practice acted on reported incidents and national patient safety alerts as well as comments received from patients.

The practice had no reported safety issues arising from staff or patients comments within the last two years. Historically staff meetings had not been carried out. These meetings had recently been introduced with the appointment of the new practice manager. The last meeting was held on 22 January 2015.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was one recorded significant event within the last 12 months, relating to staff practices, which the practice had reflected on and shared learning regarding providing greater support to staff when they undertook new roles. The review of the significant events and incidents was a standing item on the practice meeting agenda. The practice staff we spoke with told us they were committed to identifying and learning from any such incidents should they occur.

Staff knew to report concerns to the practice manager or GP. They were responsible for completing the significant incident report that could be accessed either on the practice computer system or manually completed. It required details of the event and analysis such as preventable factors, non preventable factors and an action plan if required.

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 for which they were responsible. They also told us alerts were shared and discussed at their January 2015 meeting. All staff were aware of any actions that were required.

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 on safeguarding. We asked members of the clinical 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. The staff knew how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The GP was the lead in safeguarding vulnerable adults and children. The GP was trained to the appropriate to enable them fulfil this role. All staff we spoke were aware who the lead was and who to speak with in 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 vulnerable adults were highlighted on the patient record and were known to staff.

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). All clinical staff had received a verbal briefing on the role of a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Some reception staff would act as a chaperone if clinical staff were not available, although infrequently. The reception staff also had received a verbal briefing but had not undertaken a criminal records check through the Disclosure and Barring Service to check their suitability in the role and no risk assessment had been conducted. The practice manager assured us that it would be addressed as a priority.

Good

Are services safe?

The practice had a system for identifying patients with a high number of A&E attendance and these were reviewed annually. Staff told us that this helped them to help identify patients who were vulnerable and plan to support and them . Practice staff demonstrated that they reviewed and monitored incidents such as where children persistently failed to attend appointments e.g. for childhood immunisations. If the patients were known to the practice and consented, the practice would call the child's family before the appointment as a polite reminder. The practice told us they also responded to changes in circumstances and facilitated appointments for children, where possible, often with little to no notice.

The practice had a system in place to identify vulnerable patients, the nature of their vulnerability and how the practice could best support them. There was also a system for reviewing repeat medications for patients with co-morbidities/multiple medicines and where patients were on high risk medicines requiring addition health reviews.

Medicines management

We checked medicines stored in the treatment rooms and medicine fridges. We found they were stored insecurely and were accessible to patients. For example, we found that medicines were stored on a low level trolley accessible to children. This was raised with the practice during our inspection. The practice acknowledged the risks and removed medicines immediately from the reach of patients. The practice had no arrangements in place to assess and manage the risks associated with a power failure in relation to the storage of vaccines e.g. the power being switched off accidentally. This could damage the integrity of the medicines as they may not be refrigerated as required. The practice agreed to look into systems to notify them should any disruption to the power occur.

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.

We found the GP conducted an annual prescribing review of his data with the Clinical Commissioning Group prescribing advisor. As a result, the GP was prescribing below budget and had reduced patient dependency on medication.

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

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.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the safe destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual, quantities, dose, formulations and strength. Staff were aware of how to raise any identified concerns with the controlled drugs accountable officer in their area.

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.

The practice had a lead practice nurse for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and also updates relating to isolation facilities, contagious disease management and hand washing refresher courses. We found that the practice had not conducted an infection and prevention control risk assessment. Therefore, the practice had not identified potential risks required to be addressed and action plans detailing them.

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, hand gel and hand towel dispensers were available in consultation and treatment rooms.

The practice conducted an annual risk assessment for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice nurse checked water could not stagnate anywhere in the system and water cisterns were kept covered, insulated and clean. The last assessment was conducted in December 2013 and was scheduled to be reviewed in February 2015.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was 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 of February 2015. A schedule of testing was in place. We saw evidence of the calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices.

We found that a mercury sphygmomanometer (blood pressure measuring device) was still in use. Clinicians we spoke with told us that they considered results using this device to be more accurate than alternative electronic blood pressure monitoring devices. The practice did not have arrangements in place for dealing with mercury spillage should the sphygmomanometer become damaged. Guidance from the Medicines and Health products Regulatory Agency recommend appropriate health and safety procedures should be maintained including the availability of mercury spillage kits. When we brought this to the attention of the GP and practice manager they assured us they would purchase an appropriate spillage kit as they valued the use of the device for accurate data.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the personnel file of a recently employed member of staff to see if they were following their policy. It contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification had been sought, references, medical suitability to undertake the role and their qualifications.

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 all 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 it written into their contracts to attend work at for short notice to cover for staff absences.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included visual checks on the building, the environment and medicines management, staffing and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff as was their liability insurance and the practice manager was the identified health and safety representative.

There was no overarching risk log, identifying and assessing each risk, rated and mitigating actions to reduce and manage the risk. However, we saw staff considered and recognised risks and could provide us with examples to illustrate how they were discussed and managed. For example, the practice had non slip rugs on the waiting room floor to reduce patients slipping on the floors during wet weather.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health

and well-being or medical emergencies. For example, staff told us of how the GP assisted a patient whose health had deteriorated whilst at the practice, whilst staff requested the attendance of an ambulance.

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 such as the 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 practice did not have access to emergency oxygen. Current resuscitation guidelines published by the The National Resuscitation Council emphasis the use of oxygen, and this should be available whenever possible. Oxygen is considered essential in dealing with certain medical emergencies (such as acute exacerbation of asthma and other causes of hypoxaemia). The practice considered that this clinical need could be best met by the ambulance service who would be requested to respond to an incident.

Emergency medicines were held in the GP medical bag and a clinical room. Some of the emergency medicines such as the anaphylaxis kits were accessible to patients. We checked the medicines and found there was no treatment for hypoglycaemia (low blood sugar). In particular, no oral glucose and no injections of glycogen which would be used to prevent the potentially life threatening consequences of hypo glycaemia. When we spoke to the GP, they confirmed such medicines would be made available for an emergency. We found processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and 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, contact details for the alternative operating site in the event the practice was unable to access their facilities and details of utilities should the lighting, heating or water systems fail.

The practice had carried out a fire risk assessment with the assistance of Essex County Fire and Rescue Service on 17 September 2014 and had obtained a satisfactory standard of fire safety. Records showed that weekly fire alarm testing was undertaken, monthly emergency lighting checks and fire equipment including extinguishers had been checked on 8 April 2014. We found not all staff had undertaken training in fire safety including the use of extinguishers but were aware of how and where to evacuate to in the event the building was unsafe. The practice manager agreed to revisit staff training needs to ensure all staff had received appropriate training.

We found risks associated with service and staffing changes (both planned and unplanned) were documented within the business continuity plan. We saw an example of arrangements in place in the event of the GP being sick and unable to attend and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The clinical team 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) and from local commissioners. They had no practice clinical meetings and did not believe such were warranted. The practice held regular discussions with other health professionals coordinating and agreeing patient care plans outside a formal meeting. All discussions and decisions were reflected within the patient record. 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 GP and nurses that staff completed thorough assessments of patients' needs and these were reviewed. We found the practice nurses completed detailed asthma assessments using review templates aligned to the QOF requirements. (QOF is a voluntary incentive scheme for GP practices in the UK).

The GP told us they led in all clinical areas but had a specific interest in hypertension (high blood pressure) management. The GP was able to demonstrate a higher than national prevalence of Hypertension and Atrial Fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) amongst the practice patients. As a consequence of their early identification and treatment for hypertension the GP reported lower than national prevalence of Stroke (blood supply to part of the brain is cut off), Ischaemic Heart Disease (reduced blood supply to the heart) and Myocardial Infarction (Heart attacks).

The GP showed us that the practice's performance for antibiotic prescribing was good with lower prescribing rates than average when compared to similar practices, demonstrating that antibiotics were being prescribed appropriately. We were shown the process the practice used to review patients recently discharged from hospital. All patients were individually reviewed and care plans developed and managed by the GP.

The practice told us they did not currently compare their referral rates to comparable practices. They had not audited them but had proposed suggestions to the Clinical Commissioning Group to reduce their referral rates without compromising patients' access to timely and appropriate care.

Discrimination was avoided when making care and treatment decisions. Interviews with the clinical team showed that the culture in the practice was that patients were cared for and treated based on need. 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 reviews and medicines management. The information staff collected was then collated by the practice manager to support performance assessments.

We looked at two clinical audits that had been undertaken in the last year. Both were completed audits where the practice was able to demonstrate improvements resulting from the findings of the initial audit. For example, the GP conducted audits on their vasectomy and minor surgical procedures to ensure they were operating in line with their registration and National Institute for Health and Care Excellence guidance. The GP audited the experiences of patients and their GP who had made the referral, operation success rates and complication rates and amended their practice accordingly. The GP also welcomed clinical supervision from a consultant urologist when assisting the consultant with vasectomy reversals.

The GP 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, we saw an audit regarding atrial fibrillation (fluttering heart rate). It showed that early referrals to specialists and appropriate medical interventions provided by the GP had reduced patient risks of a stroke.

Good

Are services effective?

(for example, treatment is effective)

Clinical audit tools, staff discussions and meetings were used to assess the performance of clinical staff. Whilst staff were aware of their role in improving outcomes for patients principally in accordance with the QOF these were not detailed within the meeting minutes reviewed.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that some 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 and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GP had oversight and a good understanding of best treatment for each patient's needs.

We found there was a system in place for the management of high risk medicines. However, we found this was not sufficiently effective with some patients not receiving timely and appropriate medication reviews. We found some patient records did not identify who was leading on the patient's care, such as the GP or hospital or whether it was shared between them. For example, a patient issued with methotrexate (disease modified drug) was issued the medicine without a necessary medication review and without a pre-set review date. In the absence of clinical ownership the patient may be at risk of deteriorating health. This was accepted by the practice who agreed to ensure patient records were clearly marked up with the clinician who is leading on their care.

The practice also participated in local benchmarking run by the Basildon and Brentwood Clinical Commissioning Group (CCG) especially in relation to prescribing data. 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 or exceeding other services in the area.

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 courses such as annual basic life support. We noted that whilst the practice team was small the staff had a complementary skill mix and appreciated each others strengths. The GP was up to date with their yearly continuing professional development requirements and had a date for revalidation of March 2015. (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 received annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that an initial skills and development needs assessment were conducted on their appointment.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, nurses had been trained in travel and health specialisms such as the administration of vaccines.

The practice manager told us that systems were in place to manage poor staff performance The process involved providing support, training and development opportunities to staff concerned before considering performance management procedures.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 South East Essex Doctors Service both electronically and by post. The practice staff were clear in their roles and responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Systems were clear and effective at ensuring all information was entered onto the electronic clinical record prior to being shared with the GP, who saw all documentation including results. The GP reviewed the information on the day of receipt and was responsible for actioning it. All staff we spoke with understood their roles and felt the system in place worked well.

The practice did not hold multidisciplinary team meetings to discuss patients with complex needs, for example those with end of life care needs or vulnerable people. Instead issues were discussed with health partners as they arose and decisions documented on the patient record. For example, the district nursing team had shared access to the

patient electronic record. Therefore, the GP and the nursing team tasked one another to ensure all aspects of care were being met. Staff felt this system was more timely, and worked well in responding to patients' individual care needs whilst sharing important information.

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, 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 then scanned the letter into their patient record system to record the information issued to the patient. The staff told us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 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 an electronic patient record SystmOne 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.

Consent to care and treatment

We found that the GP was aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and the duties in fulfilling it. The GP understood the key parts of the legislation and were able to describe how they implemented it in their practice. The GP told us how they held discussions with patients and their relatives where appropriate regarding 'do not attempt resuscitation orders'. The GP was committed to, and patients confirmed they were supported to make their own decisions and these were documented in the medical notes.

The GP encouraged patients at the early stages of dementia diagnosis to review their wills and power of attorney to safeguard their rights. 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 was sent detailed information on the procedure and post-operative care. Verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We looked at ten patient consent records for the last sterilisation procedures performed at the practice. We found all patients had consented to the procedure and the practice had engaged with the patient's wider family with their consent. The practice had declined to conduct surgery where they had concerns regarding the patient's understanding of the consequences of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

We found that all staff educated and encouraged patients to take responsibility for their own health and the management of their medical condition, whilst at the same time providing a safety net to support them in the event they were unable to. This was confirmed by a patient with whom we spoke on the day of our inspection. They showed us how they monitored their daily blood pressure and presented the GP with the data to inform their medication reviews.

It was practice policy to offer a health check with the 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 clinical staff to use their contact with patients to help maintain or improve mental, physical

Good

Are services effective?

(for example, treatment is effective)

health and wellbeing. For example, staff offered opportunistic screening to patients with long-term conditions who required periodic health checks and reviews.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 62 patients were applicable for the health checks and 22 had taken up the offer of them out of a patient population of 900. The GP followed up with the patients if they had risk factors for disease identified at the health check and scheduled further investigations.

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 all four patients on their patient list had been offered and accepted their annual physical health check.

The practice had identified potential discrepancies with their data in relation to the recording of the smoking status of patients as some patients were showed as both smoker and non-smoker. Therefore, within the last 12 months, the practice had asked 318 patients who were thought to smoke to clarify their smoking status. 84 patients were offered support and/or treatment and 29 patients were referred to a specialist or provided additional smoking advice.

The practice had 141 eligible patients who were offered cervical smear tests and 109 had accepted the screening invitation. The practice sent follow-up letters and telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. The practice had identified patients with poor mental health were overrepresented within the number of patients who failed to attend screening appointments. The practice was proposing to work with the patients and specialist mental health advisors services to enhance the uptake of screening programmes for this population group.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and this current year the practice had vaccinated all of their children. The practice had a clear and effective policy for following up non-attenders by the named practice nurse.

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 Patient Survey 2014, and patient satisfaction questionnaires sent out to patients by the practice. The results of the National Patient Survey found the practice performed well. All of the 120 respondents stated they found it easy to get through to the practice on the phone and had a good experience of making an appointment. 98% of the respondents thought the GP was good at giving them enough time. However, 48% of respondents commented on having to wait 15 minutes after their appointment time to be seen. Patients spoken with on the day had also experienced delays but appreciated how caring and attentive the GP was and understood why this sometimes resulted in the GP running a little behind schedule. The GP was mindful of patients waiting and reception staff apologised to patients where delays occurred.

The evidence from 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 patient feedback about the performance of the GP showed all of the 59 patients who responded were confident of the GPs ability to provide care and were happy to see them again. Comments from patients again referred to the GP's patient, caring and committed approach to providing care to his patients.

We reviewed patient comments recorded on the NHS Choices website. Seven entries had been recorded over the past 12 months and all were extremely positive. Patients commented on the availability of same day appointments, that the GP listened to them, cared and followed up on issues including conducting home visits as required.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards and all were overwhelmingly 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. All told us they were 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. 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 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 had a separate room away from the reception desk which helped keep patient information private.

Staff told us that if they had any concerns, 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.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. They generally rated the practice well in these areas.

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 were also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The National Patient Survey information we reviewed showed patients were positive about the practical and emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were

Good

Are services caring?

also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, told patients how to access a number of support groups and organisations. The practice's computer system alerted the GP 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 where families or an external health service such as a hospital or hospice reported a bereavement, the GP contacted the family. 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

We found the practice was responsive to patients' 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. We saw minutes of the monthly and quarterly meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its patient population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patients. For example, at the time of our inspection the practice was piloting earlier opening times to align to other practices within the Billericay area. Although appointment analysis that had been undertaken did not show patient demand for the earlier opening.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Late opening was provided on Wednesday evening until 7pm and priority appointments were available for children after school and during lunchtimes to minimise disruption to their education.

The practice recognised a growth in the number of eastern European patients registering with their practice and locally within the community. They had access to translation services although none of their patients currently required the service. The practice was intending to advertise the service to provide additional reassurance to patients whose first language may not be English.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed equality and diversity training in the last 12 months. They told us equality and diversity issues were regularly discussed at staff appraisals regarding patients receiving equitable access to services and were considered when reviewing and resolving issues.

The practice premises had been adapted to meet the needs of patients with disabilities. The practice benefited from on site parking facilities and step free access. There was a large and bright waiting area with sufficiently wide corridors to accommodate people with mobility issues or prams/pushchairs. This made movement around the practice easier and helped to maintain patients' independence. There were patient toilet facilities and a small lowered toilet bowel specifically to accommodate young children.

Access to the service

Appointments were available from 8am to 6.30pm on Monday, Tuesday, and Friday with early closing on Thursday at 1pm. If patients needed to see a doctor when the practice was closed, they were directed to the out of hour's service. The practice remained open on Thursday afternoon despite providing no clinics. This was to ensure patients could collect prescriptions or speak directly with staff regarding their enquiries. The practice was closed during lunchtimes between 1pm and 2pm. 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 and details of how they could contact the GP direct, if they required emergency medical advice.

Longer appointments were available for patients who needed them. Whilst double appointments were not advertised they were facilitated where requested by either patient or doctor. Home visits were made to patients after morning surgery.

Patients were very satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice.

The practice operated extended opening hours on Wednesday until 7pm, specifically targeted to people who worked and principally commuted. However, they found little demand for this evening service and experienced a high late cancellation rate.

The practice were sensitive to people with poor mental health. They offered them greater flexibility regarding access to and duration of appointments, including offering

Good

Are services responsive to people's needs?

(for example, to feedback?)

them appointments at the end of morning surgery or during quieter times. The practice felt this was well received by patients, providing individualised care in a quiet and supportive environment. This was intended to reduce potential stress for the patient and reassure them they would be treated without fear or prejudice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system, a poster was displayed within the reception area. Patients were invited on the patient information leaflet to make comments, suggestions and complaints but it did not provide details of the practice complaint procedure. Patients we spoke with told us they were happy with the service they received and confident that should they have concerns they would report them to a staff member who would address them appropriately.

The practice had received no complaints within the last three years. Staff were aware of the importance of recording both written and verbal complaints but none had been received. We reviewed the practice team meeting minutes from January 2015 and saw that complaints and comments were addressed on the agenda.

The practice had a suggestion box within the patient waiting area but they had received no comments.

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 spoke with members of staff and they all knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these. We saw this in respect of all staff members including non clinical staff encouraging patients to take responsibility for their own health and the management of their medical condition. Whilst being accessible and supportive when they required assistance.

The practice had discussed succession planning with NHS England but their short term intentions were to enhance their specialist surgical services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff within the practice, a paper record system was also maintained. A designated member of staff was appointed as responsible for reviewing the policies to ensure they were accurate and reflective of best practice. Most of the policies had been written within the last 12 months and the practice was considering the best means of ensuring they remained current. Where alerts were received such as in relation to safeguarding practice or medicines the policies had been reviewed to ensure they were still suitable for use. However, the practice acknowledged this was an area requiring further development.

There was a clear leadership structure with members of staff having lead roles. For example, there was a practice nurse responsible for infection control and the GP was the lead for safeguarding. We spoke with five members of staff and they were all clear about their own roles and responsibilities. They told us they enjoyed working at the practice and 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 regularly discussed amongst staff and patients with outstanding needs registered on their patient record were actively followed up to improve outcomes.

Although the practice could identify risks there was limited evidence of documented arrangements for identifying, recording and managing these, other than the contingency plan and fire risk assessment. The practice had only recently introduced practice team meetings and had no evidence of earlier governance discussions reviewing practice performance, quality and risks.

Leadership, openness and transparency

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues directly with the GP or staff member or during team meetings. We also noted that the team were rewarded for achievements such as being taken for meals and given gifts during significant public holidays or religious festivals.

The practice manager had responsibility for overseeing the human resource policies and procedures. We were shown the electronic and manual staff handbook that was available to all staff, which included information on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies, if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through suggestion boxes, speaking with patients and reviewing the findings of the National Patient Survey and the practice survey undertaken to contribute towards the GP appraisal.

The practice did not have a Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who work with the practice to improve services and the quality of care. However, they had a patient representative who attended the local patient engagement forums where all local practices were represented to discuss patient concerns. The representative told us the patients thought highly of the service they received from the practice.

The practice had gathered feedback from staff through daily discussions, staff meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they enjoyed their jobs and felt involved and engaged in the practice to improve outcomes for both staff and patients.

Are services well-led?

Good

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and could be accessed electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. New staff members received a monthly review, three monthly and six monthly review and a training and development needs assessment. Staff were invited to comment on their strengths and aspects of their role they least enjoyed. Staff told us that the practice was very supportive of training and that they were taken for lunch to acknowledge and celebrate achievements as a team.

The practice had arrangements for learning and improving patient care through reviewing incidents such as significant events when they occurred.