Dickens Place

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dickens Place Surgery on Wednesday 11 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive 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 and addressed.
- Risks to patients were assessed and well managed, except those relating to reference checks for recruitment of staff.
- 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 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.
- 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.

However there were areas of practice where the provider needs to make improvements

Summary of findings

Importantly the provider should;

- Maintain a record of training undertaken by staff.
- Have access to 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. 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 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 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.

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 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. 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 and other stakeholders.

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 partner meetings. There were systems in place to monitor and improve quality and identify risk. The practice listened to feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and felt supported and valued.

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

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP and were included on the practice's 'unplanned admissions avoidance' list to alert staff to people who may be more vulnerable. The GPs carried out visits to people's homes if they were unable to travel to the practice for appointments. The practice worked with local care homes to provide a responsive service to the people who lived there. They maintain a frailty register working with partner services to coordinate patient care.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them. Patients also benefit from access to independent specialist advocacy services.

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 such as diabetes, Asthma clinic, Spirometry and Chronic Obstructive Pulmonary Disease (COPD) clinic , Chronic Heart Disease (CHD) clinic, Chronic Kidney Disease clinic and Hypertension clinics. 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 people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

We found specialist nurses trained in operating onsite facilities of Spirometry, an electrocardiogram which records the electrical activity of the heart and 24 hour Ambulatory blood pressure monitoring, contributing to reducing hospital referral rates and waiting times and facilitating diagnosis of Asthma, COPD and Hypertension. Patients have personalised care plans and were provided information to support self management of their conditions.

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. The practice had an appointed clinical lead for child protection concerns. Immunisation rates were high for all standard childhood immunisations and non attendance was followed up. 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 who attended the practice on Wednesday afternoons to provide antenatal services. They work closely with the GPs who conduct post natal maternal check ups and six weekly baby checks.

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, including the opportunity to book appointments six weeks in advance and arrange repeat prescriptions. The practice provided a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people through opportunistic and scheduled reviews. 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. Patients also benefit from accessing independent specialist advocacy services with knowledge of supporting vulnerable people, carers and people living independently.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice has an appointed mental health lead and a mental health specialist

Summary of findings

nurse. The practice invites people with poor mental health to attend annual physical health checks and follows up on non attendance. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice has focussed on improving their dementia care to patients and have undertaken specific training and enhanced their outcomes for patients. Patients also benefit from accessing independent specialist advocacy services.

Summary of findings

What people who use the service say

Although we were not able to speak with patients directly during the inspection, we gathered feedback from patients from the practice by looking at CQC comment cards patients had completed. We received one response from a patient who told us the staff were friendly and caring, they felt listened to were treated kindly and efficiently. We also spoke to a local care home whose residents attend the practice and they told us the patients had a good relationship with their GPs and received a prompt and helpful service.

We spoke to the district nursing team who work with the practice and they told us the practice staff were polite and responsive to patient needs. Where professional differences had occurred regarding clinical treatment for patients all parties had worked together to find a timely and appropriate outcome in the interests of the patient.

Data available from the NHS England GP patient survey showed that the practice scored in the upper range nationally for satisfaction with the practice, with many patients reporting a good overall experience of the practice and involvement in decisions about their care.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

- Maintain a record of training undertaken by staff.
- Have access to emergency oxygen

Dickens Place

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dickens Place

Dickens Place Surgery is located on the outskirts of Chelmsford. The practice provides services for approximately 5918 patients living in the immediate area. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by NHS Mid Essex Clinical Commissioning Group.

The practice is managed by two partner GPs supported by clinical staff; two salaried GPs, registrar,(GPs in training) three practice nurses and a specialist nurse in diabetes and coronary heart disease. The practice also employs a practice manager, an assistant manager, five reception staff and two medical secretaries who job share.

The practice is open from 8.00am to 7pm weekdays. GP appointments are available between 9am and 12:00 and between 4pm to 6pm on Monday to Friday. Late clinics are provided three evenings a week between 6.30pm and 7.30pm on Tuesday, Wednesday and Thursday. Nurse led appointments and clinics are also available with ante-natal clinics held on Wednesday afternoons. Routine appointments can be pre-booked up to six weeks in advance in person, by telephone or online and home visits are available daily as required.

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 the 111 service, an out-of-hours advice, emergency and non-emergency treatment service. Details of how to access out-of-hours advice and treatment is available within the practice, on the practice website and in the practice leaflet.

Why we carried out this inspection

We inspected this service as part of our 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 carried out an announced visit on 11 March 2015. During our visit we spoke with a range of staff, administrators, clinicians and the practice manager and reviewed a comment card completed by a patient 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, reported incidents and national patient safety alerts as well as comments and complaints received from patients. 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 manager prints off the patient safety alert, shares them with the nursing team who review patients who may be adversely affected and advises the GPs, making recommendations such as a medication review for the patient. The nursing team maintained their own administrative file for the clinical teams reference and an additional file was maintained by the administrative team for reference.

We reviewed safety records, incident and accident reports. Five accidents had been recorded over the past 15 months. These were reviewed by the practice manager and discussed with the partners where appropriate to mitigate the risks of reoccurrences. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

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 seven significant events that had occurred during the last eight months and we were able to review these. Significant events were recorded on the practice meeting agenda where appropriate. We reviewed three of the seven significant event recorded. All the significant event records included an explanation of the event, they explored what went wrong and what they could have done better and identified learning and development . For example, the practice had identified that improvements were required around better informing patients about necessary changes to their prescriptions.

There was evidence that the practice had learnt from these events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, all had learning cascaded through their line management. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff principally raised concerns verbally with the practice manager or the clinical team. The practice acknowledged that not all records were kept in respect of some less serious incidents. The practice manager told us that these issues were dealt with and resolved as and when they occurred. We saw that when patients had complained about service or clinical treatment these had been addressed, the issue resolved and an apology issued where appropriate.

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 clinical staff had received relevant role specific training on 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 and record information of concern, and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible to staff within the practice.

Staff had undergone safeguarding training on their initial appointment. Staff were spoken to regularly by the practice manager regarding identifying and escalating concerns. The practice had appointed a dedicated GP as leads 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 of these leads 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. The practice nurses followed up with children's families who persistently fail to attend appointments e.g. for childhood immunisations..

There was a chaperone policy, a notice for chaperone services was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone and where to stand to be able to observe the examination.

Good

Are services safe?

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults.

Medicines management

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, which described the action to take in the event of a potential 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. Staff explained how they had responded to recommendations made from clinical audits to improve patient care.

The 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 nurses 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. A GP is responsible for overseeing all such patients and ensuring appropriate action was taken on test results.

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. The treatment room was clean but the layout presented challenges to maintaining this, as it was used as a store facility for equipment. We saw there were cleaning schedules in place and cleaning records were kept. The practice patient survey of 2014, found patients reported the practice was clean and they had no concerns about cleanliness or infection control.

The practice had practice nurses who led for infection control but who had not undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Some staff, such as the practice manager had undertaken infection control training on line in January 2015. The practice did not have details of which staff had undertaken the training.

We saw evidence that an infection control audit in October 2014. However it did not acknowledge the additional risks of conducting surgery in the treatment room. Areas identified for improvement were not supported by an action plan but had been addressed. The improvements made had not been recorded.

The practice employed a cleaning contract company for general cleaning. We saw there were cleaning schedules in place for general and clinical areas. The practice nurses told us that they were responsible for cleaning the treatment room in between patient consultations. Nursing staff and the practice manager told us that regular visual checks were carried out on premises, equipment etc. to ensure that they were clean, however these were not recorded.

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 treatment rooms and consultation rooms.

The practice had commissioned a risk assessment for legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We found an it had been conducted 31 October 2012 and the report made a series of recommendations which the practice had followed to mitigate the risks. The practice confirmed they carry out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Good

Are services safe?

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, last conducted 2 December 2014 and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and vaccination fridges thermometers was conducted in January 2015.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, 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. However, the clinical staff members file reviewed did not contain evidence of references being obtained. The practice manager had spoken with the staff members previous employer and the clinician had worked for the practice in a locum capacity and they were happy with their work.

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. We reviewed partner meeting minutes and saw that locum cover was discussed and agreement made to ensure clinical cover during planned absences by the GPs. There were also arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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 daily, monthly and annual checks of the building, the environment, medicines management, staffing, dealing with emergencies and maintenance of equipment. The practice had a health and safety policy, but acknowledged that they may benefit from the appointment of a health and safety representative to identify risks, implement changes and monitor improvements.

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, there were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of when they had to obtain immediate medical intervention for patients.

The practice staff had a good working knowledge and understanding of people who presented with mental health needs. This was aided by the attendance of Improving Access to Psychological Therapies (IAPT) therapists who provide clinics on a Monday morning. Patients reported valuing the accessibility and support of the service.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Those not currently up to date had been scheduled to receive training in April 2015. Emergency equipment, consisting of an automated external defibrillator (used to attempt to restart a person's heart in an emergency) was available. The practice did not have access to emergency oxygen, Current resuscitation guidelines published by the The National Resuscitation Council emphasise 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 had discussed this and the risks associated with the storage and maintenance of the equipment. This was still under review at the time of our inspection. However, when we asked members of staff, they all knew the location of the emergency equipment and records confirmed that it was checked regularly.

Emergency medicines were available in secure areas of the practice and all staff knew of their location. However, the medicines were dispersed with some stored upstairs in the administrative area, not immediately accessible during an

Good

Are services safe?

emergency. The practice may benefit from ensuring the medicines are stored in one central accessible location to avoid confusion and unnecessary delay in providing treatment and care. The medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice, dated October 2014. Each risk was identified 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 of a heating company to contact if the heating system failed. The practice manager retained a copy of the policy off site in the event that they were unable to access the building.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The fire equipment had been checked in March 2015. The practice spoke to staff regularly regarding evacuation but staff were not confident in using the fire equipment. The practice is currently researching training for staff to undertake to increase their awareness and confidence in an emergency.

Risks associated with service and staffing changes planned and unplanned were included on the practice contingency place. We saw an example of this where clinical staff duties were able to be covered at short notice by staff accepting additional shifts or commissioning locum cover.

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) and from local commissioners. We found joint clinical meetings were held every three months where new guidelines were disseminated. 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 National Institute for Health and Care Excellence NICE guidelines, and these were reviewed when appropriate. We reviewed the clinical meeting minutes and feedback minutes from a primary care development day attended by a GP. These provided additional and clear guidance to staff on changes to clinical practices and referral routes to assist patients to received effective and timely access to specialist services.

The practice nurses told us they lead in specialist clinical areas such as, asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Disease (CHD) and diabetes. 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. We reviewed clinical meeting minutes, they showed that clinical issues were discussed and actions proposed to improvement the management of patients conditions. For example, a practice nurse was advised to notify lead clinicians of patients with new diagnosis of atrial fibrillation to ensure they were aware and could oversee the patients care.

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 on the basis of 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 medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out performance reviews.

The practice showed us a clinical audit that had been undertaken in the last year. The practice had reviewed the criteria for patients diagnosis of dementia and their management of them. They found in November 2014 that 33 %of their dementia patients were receiving face to face consultations. By end of January 2015 they had improved their review rate to 73%. This meant they had reviewed patient care and engaged them in the development of their care. They also reviewed the number of patients to ensure appropriate checks were undertaken and recorded. This had been done in 100% of their newly diagnosed dementia. Clinical staff had also attended specific training to improvement their understanding and treatment of patients with dementia. Staff told us they felt the audit was helpful in identifying areas for improvement and they were pleased with the changes they had made to improving patient outcomes.

The GPs told us clinical audits were often linked to medicines management information and 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 had been conducted by the practice registrar relating to whether patients were safely prescribed drugs within the practice, dated June 2014. The audit specifically looked at whether gastro-protective medication had been offered to appropriate patients such as the elderly who may be more prone to developing gastrointestinal side effects. As a result of the audit some prescriptions had been discontinued and some patients had been put on gastro-protective medications along with non-steroidal anti-inflammatory medicine. The audit was presented to the clinical team including the nursing team and it was recommended that the practice employs co prescribing as per NICE guidelines. These were accepted by the practice.

The Mid Essex Clinical Commissioning Group (CCG) had produced a benchmark comparison across the CCG and with the Midland and East England. We reviewed their report and found the practice showed evidence of cost effective prescribing in the data.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice was previously identified as an outlier for aspects of QOF (or other national) clinical targets such as dementia reviews, influenza uptake, smoking status and testing for protein in the urine of diabetic patients. The practice reviewed their performance in all areas identified and have improved clinical performance in all.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Some staff we spoke with told us that they did not collectively reflect on the outcomes being achieved and areas where this could be improved. However, we reviewed practice meeting minutes and clinical team meeting minutes and found clinical outcomes were discussed including strategies to improve the outcome of patients. All staff spoke positively about the culture in the practice.

There was a protocol for repeat prescribing which was in line with national guidance. 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 and that the latest prescribing guidance was being used. The IT 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 did not operate the gold standards framework for end of life care. However, it maintained a palliative care register and had regular internal reviews of care plans as well as multidisciplinary meetings, held three monthly to discuss the care and support needs of patients and their families.

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 mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one GP specialising in rheutmatology, asthma and Chronic Obstructive Pulmonary Disease.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

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 supporting relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered access to a senior GP throughout the day for support.

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 and cervical screening (smear tests). Those with extended roles 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.

The practice had not experienced poor performance by staff but in the event that they did the practice would support the staff through training and development.

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 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.

Good

Are services effective?

(for example, treatment is effective)

The practice was commissioned for the new enhanced service and had a process in place to follow up patients on unplanned admissions (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice allocated applicable patients an allocated GP and had a care plan which was reviewed regularly. The practice had reviewed their data which suggested a reduction in the number of patients having unplanned admissions. The GPs ensured all patients care plans were actively reviewed to reflect and meet their individual needs.

The practice held multidisciplinary team meetings on a Friday to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by community matrons, Macmillan nurses, a Registrar from the hospice, social worker and community nurses, decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of 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, this is achieved through faxing referrals to the Essex central referral system replacing 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. Although the practice did not monitor referral rate rejections.

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. 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 has 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 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 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.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. 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 / written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications 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

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 GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

Good

Are services effective?

(for example, treatment is effective)

We found all patients over 75 years had an appointed named GP to oversee and co-ordinate their care. The practice held regular multidisciplinary case management meetings to review patient care plans. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that initially they experienced a good take up rate. However, this had declined and the practice believed this was due to patients accessing the health checks via other community health providers.

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 each of 26 patients were offered an annual physical health check. Practice records showed 14 had received a check up in the last 12 months. The practice had also identified the smoking status of 77.6% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. All three of the practice nurses were trained in smoking cessation and were providing guidance on stopping or reducing smoking behaviour.

The practice's performance for cervical smear uptake was 79.2%. There was no policy for follow up on patients who failed to attend appointments as contracted services were responsible for notifying the patient and sent out three notification letters. However, clinical staff told us that they would address any outstanding items on the patient clinical record when they attend the practice.

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 again there was a clear 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 from 2014. 269 surveys were sent to patients with a response from 113 patients received. The practice exceeded the CCG average for patients experiences with 87% of patients said they found it easy to get through to the surgery by the phone. The practice respondents were also asked if they found the receptionists helpful and 86% of them did. This was reflected within the practices own patient survey conducted in May 2014. 206 patient questionnaires were completed. 97% of the patients reported the reception staff were good or very good and. With 92% of respondents reporting the GPs and nurses treating them were good or very good in providing care.

One patient completed a CQC comment card to tell us what they thought about the practice. The patient was positive about the service experienced. The patient said they felt the practice staff were friendly and caring and the premises were safe and hygienic. They believed they were listened to and dealt with kindly and efficiently. We spoke with the District Nursing Team and local care homes both spoke highly of the service patient received from the practice. They told us the patients received prompt and compassionate care from the clinicians and administrative team.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Fabric 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 switchboard was not shielded or segregated away from the reception desk. The staff were aware of this and patients were invited to speak privately with staff if they wish to.

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. 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

Patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, the National Patient GP survey found that 86% of practice respondents said the last GP they saw or spoke to was good at involving them in decisions about their care.

The results from the practice's own patients satisfaction survey conducted in 2014 showed that 87% of patients considered the service they received from the GP/nurse as good or very good when asking them about their symptoms and how they were feeling. This was also supported in 91% of respondents also reporting the GP/ nurse involving them in decisions relating to their care and explaining the condition and treatment options available to them.

Staff told us that translation services were available for patients who did not have English as a first language. However, we found no notices were displayed in the communal waiting areas. The practice have acknowledge the need to advertise the availability of this service. Although currently, they experience little demand for it. The practice actively promoted Essex Advocacy Services through notices on the wall and leaflets. The Essex Advocacy Service is a partnership of local and national providers with specialisms in family carers, deaf people, independent living and mental health services. Advocacy is a process of supporting and enabling people to: express their views and concerns. Access information and services. Defend and promote their rights and responsibilities.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

We reviewed the results from the National GP survey and found that 91% of practice respondents described their experiences of the practice overall as good. We saw staff speaking with patients and they were patient, sensitive and helpful when addressing their individual needs.

Notices in the patient waiting room, informed patients about the services provided at the practice, general health information and how to access a number of support groups and organisations. The identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer so as advice and support could be given as needed. We were shown the information recorded on the new patient questionnaire and the practice nurse discussed the implications of the patients caring responsibilities with them on their attendance.

Staff told us that if families had suffered a bereavement, it is recorded and brought to the attention of the administrative staff to mitigate the risks of insensitive comments. Some GPs contacted the bereaved family to offer them support such as information to specific support services.

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. We reviewed practice meetings, partnership meetings and clinical meeting minutes all discussed the performance of the practice and how best to improve the clinical outcomes for their patient group. They also identified where staff had undertaken training to enhance the services provided. For example, a member of the nursing team was due to complete her cervical screening training.

The practice had previously had a Patient Participation Group (PPG) who they valued but it became unsustainable for the patients. The practice told us how their involvement had resulted in the introduction of the hearing loop at reception. The practice was also researching methods of improving the sound proofing of the consultation and treatment rooms to reduce the potential of being overheard following concerns being raised by patients and staff. The practice had obtained a licence to play music in the waiting area in the interim.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. They offered extended opening three evenings a week designed to meet the needs of patients who commute or work and are unable to attend during 9am - 5pm. The practice had access to telephone translation services.

Some staff had undertaken equality and diversity training through e-learning. The training was optional although staff were encouraged to undertake it. The practice did not monitor the training undertaken by staff but were proposing to establish a training matrix to enable greater oversight of staff development and learning needs.

The practice clinical rooms were situated on the ground floor of the building and accessible to patients. The premises had been adapted to meet some of the needs of patients with disabilities. They had a no step access into the premises and a lowered reception desk for people who used wheelchairs. Automatic sliding doors had been considered for the reception area however, this was not achievable without significant structural changes to the building. Staff were aware of potential difficulties patients with mobility issues may experience and were happy to help them with opening the entrance doors.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. A hearing loop was available for patients with hearing difficulties.

Access to the service

The practice is open from 8.00am to 7pm weekdays. GP appointments are available between 9am and 12:00 and between either 4pm to 6pm on Monday to Friday. Late clinics are provided three evenings a week between 6.30pm and 7.30pm on Tuesday, Wednesday and Thursday. Urgent appointments with the GP or nurse were available on the day. Nurse led appointments and clinics are also available with ante-natal clinics held on Wednesday afternoons. Routine appointments can be pre-booked up to six weeks in advance in person, by telephone or online and home visits are available daily as required.

Comprehensive information was available to patients about appointments on the practice website. 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.

The practice offered an online booking system available and text message reminder for appointments. These they found were particularly useful services for their patients who commute. 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. Home visits were made to local care homes where clinical needs arise and often by the patients named duty where applicable.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Some patients had expressed some dissatisfaction with the appointment system. Although, the practice survey conducted in 2014 found 77% of respondents reported being able to see a GP the next day, same day or within two days. The survey also identified that 19% of their patients were unaware that urgent on the day appointments could be booked with a GP or nurse. The practice was actively trying to address the availability of clinical appointments whilst also educating their patients on the range of services available to best manage the growing clinical need. The practice is currently actively advertising for a partner or salaried GP and/ or a nurse practitioner. They are awaiting the outcome of this latest recruitment campaign which is being extended.

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. This information was available in the practice leaflet, an additional complaints leaflet and published on the practice website.

We looked at the practice complaints and complements received. Nine complaints had been received in the last 12 months. All had been acknowledged by the practice manager in a timely manner, clinical issues were escalated to the clinicians and reviewed and responded to appropriately. For example, a health professional had raised concerns regarding the accessibility treatment to end of life patients. We found the practice had listened to and accepted opportunities to work with the McMillan nursing team and pain consultant from the local hospice to enhance their understanding of pain management.

We reviewed the practice meeting minutes and minutes from the GP partner meetings. Complaints were discussed on the agenda where there was a need but the response not delayed awaiting these. Where complainants were not satisfied with the outcome of the complaint they were provided with the details of the Ombudsman. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learnt from individual complaints had been acted on. The practice also retained complements received from patients and these included comments thanking the reception staff for their patience and care and the clinical team for their support.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. All staff we spoke to during the inspection were positive about the practice and committed to delivering good care to patients. They understood the growing clinical demand by patients and the challenges these presented to the practice who had limited space to increase their clinical rooms.

The practice confirmed there was no documented short or long-term strategy in place for the practice but they had contributed to the CCG two and five year business plan. The practice accepted that there may be benefits to forecasting future clinical need and developing a business plan to set our how they intend to meet the challenges. Despite the absence of a formal strategy all staff were aware of the partners intention to increase the size of the clinical team.

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. The practice manager initially produced the policies and procedures three years ago and reviewed them annually or as required relating to policy or guidance development. Staff were encouraged and invited to read those policies appropriate for undertaking their roles and responsibilities. The practice did not maintain a record of which policies staff had read or checked on their understanding of them. However, where specific issues have arisen for example the sharing of patient confidential information. Staff were advised and supported to access the relevant guidance and their understanding checked prior to undertaking the role.

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 the GP partner was the lead for safeguarding. We spoke with clinician and administrative 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 practice/partner meetings. Actions plans were not produced but issues reviewed verbally and addressed to maintain or improve outcomes.

The practice had identified risks to the practice. There were clear contingency arrangement in place such as the practice manager having a deputy and locum clinical cover in the event of planned and unplanned absence from GP.

Leadership, openness and transparency

We saw from minutes that practice meetings were held regularly, but had been delayed due to staff leave. 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 reviewed GP partnership meeting minutes that discussed a range of issues including the registration of the practice, finances and resources such as locum cover for planned and unexpected absences of GPs.

The practice manager was responsible for human resource policies and procedures. We saw the practice had a number of procedures, disciplinary procedures, induction policy, management of sickness and compassionate leave which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke said the practice were sensitive to their individual circumstances and they were confident they would receive kindness and compassion and be supported appropriately.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints.

We looked at the results of the practices patient survey, conducted in 2014 where 90% of the patients reported being able to see their preferred GP. The survey also asked patients how quickly they got to see a GP. 22% of the respondents stated they had to wait three to four days. The practice manager was aware of the increasing clinical demand and the practice were actively recruiting for a GP or nurse practitioner in order to meet the increasing demand.

Are services well-led?

Good

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

The practice had previously had an active patient participation group (PPG), but was unsustainable for the patients. The practice were considering the most sustainable and effective means of engaging with representatives from various population groups.

The practice had gathered feedback from staff through their annual appraisals, speaking daily and involvement in meetings. 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 and 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 and mentoring. We looked at four 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 were receptive to training requests.

The practice was a GP training practice aligned with East of England Deanery. The practice had one registrar working at the practice at the time of our inspection. A registrar is a GP in training who has completed their medical school training.

The practice had completed reviews of significant events and other incidents and shared with staff informally as they occur to ensure the practice improved outcomes for patients. For example, staff were reminded to confirm the identities of patients by double checking the name and date of birth of the patient to ensure the correct medical record was reviewed and data entered onto it.