Castle Gardens Medical Centre

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.

Summary of findings

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Summary of findings

Overall summary

Castle Gardens Medical Centre is in Colchester. The practice provides primary medical care to approximately 8,700 people. Castle Gardens Medical Centre is a training practice providing training for GP registrars. These are qualified doctors who wish to pursue a career in general practice.

We carried out an announced inspection on 29 May 2014.

The practice was safe, responsive and effective in meeting the needs of older people. The provider had put in place safeguarding systems which sought to protect vulnerable adults from harm. An advanced nurse practitioner visited larger care homes three times a week.

Improvements were required to ensure that the service was effective for people with long-term conditions.

The practice was safe and effective for mothers, babies, children and young people.

Castle Gardens Medical centre was responsive to the needs of working age people.

Improvements were required to ensure that the practice was caring towards people in vulnerable circumstances who may have poor access to primary care.

The practice was effective and responsive to the needs of people experiencing poor mental health.

The regulated activities we inspected were diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures, and treatment of disease, disorder or injury.

We found that the practice was not meeting all the regulations with which they were required to comply. This was because medicines were not always stored securely and systems were not in place to ensure that vaccines were not stored at the correct temperature. Systems relating to reducing the risk of infection were not fully implemented and systems to monitor quality were unclear.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found that improvements were needed to ensure that the service is safe.

The systems, processes and practices in place to keep people safe in respect of medicines management and infection prevention and control were not effective. The infection control audit had not been actioned and there was no risk assessment to identify and control the risk of infection. Temperatures of fridges used to store medicines could not be assured. We have identified these issues as a breach of regulation.

The practice had policies in place that encouraged staff to be open and transparent. We saw how this policy was used in practice.

We saw that the practice analysed and learnt from significant events although there were some gaps in the recording of these.

Are services effective?

We found that improvements were needed to ensure that the service is effective.

There was a lack of clinical audit. This meant that the practice had not effectively identified and responded to data which indicated clinical shortfalls. This meant that appropriate remedial action may not have been taken if this was required. We have identified this as a breach of regulation.

Care and treatment was delivered in line with current published best practice.

The practice positively engaged and worked in partnership with other services to meet the needs of patients. Staff received training that was appropriate to their role.

Health promotion advice was displayed in the waiting room and near to the reception desk for patients and carers. Patients told us that the GPs provided advice to support them to manage their own health needs.

Are services caring?

The service was caring.

Patients we spoke with told us that staff involved and treated them with compassion, kindness, dignity and respect. We observed sensitive, discreet interactions between patients and reception staff.

Summary of findings

Are services responsive to people's needs?

The service was responsive to people's needs.

The practice understood the needs of the patient population and made reasonable adjustments to meet those needs.

The practice offered extended opening hours so that patients were able to attend the practice when they needed to.

Complaints were responded to in a timely manner.

Are services well-led?

The service was well-led.

The lead GP was supported by a management team. This sought to ensure that there were clear governance arrangements and leadership in place.

There were mechanisms in place to encourage, hear and act on feedback from staff. Staff attended regular meetings at the practice. Meeting minutes evidenced that they were involved in the day-to-day and long term visions of the practice.

Practice education meetings occurred monthly to enable clinical staff to partake in shared learning and improvement.

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

There were effective processes in place to ensure that, in the event that an older person lacked mental capacity, the clinician knew who was legally authorised to give consent on their behalf for decisions which related to their health and welfare.

Representatives from care homes for older people who we spoke with told us that the practice was caring and treated patients with dignity and respect. The practice was responsive to the needs of older people.

Older patients who were unable to access the community were in the process of being identified on the patient record system by a read code so that proactive support and advice could be offered. A read code is the clinical encoding of people's medical history and background.

People with long-term conditions

There were systems in place which sought to ensure that people who had long-term conditions were kept safe.

The provider was unable to give explanations for negative trends identified in statistical data. This was because service had not maintained an effective clinical audit cycle.

Patients with long-term conditions told us that the practice was caring and helpful and that support was also given to their carers.

Multi-agency palliative care meetings were held monthly. Palliative care is the care given to relieve the pain, symptoms and stress of patients at the end of their life. These meetings were attended by community matrons, Macmillan nurses and care home staff. The practice had been awarded the Gold Standards Framework (GSF) accreditation for excellence in end of life care and was one of the first surgeries in the country to receive this award. The GSF is a nationally recognised multi-agency approach to palliative care.

Mothers, babies, children and young people

The practice had put in place safeguarding systems which sought to protect children from harm. Children received childhood vaccinations in line with the national NHS vaccination schedule and the Healthy Child Programme.

The practice was responsive to the needs of mothers, babies, children and young people. Information was displayed in the

waiting room advising of Saturday morning drop-in sessions at other clinics. This was where children under the age of 18 could receive their immunisations with other providers in the locality if they were unable to access this practice during the week.

The working-age population and those recently retired

The practice had put in place safeguarding systems which sought to protect children from harm. Children received childhood vaccinations in line with the national NHS vaccination schedule and the Healthy Child Programme.

The practice was responsive to the needs of mothers, babies, children and young people. Information was displayed in the waiting room advising of Saturday morning drop-in sessions at other clinics. This was where children under the age of 18 could receive their immunisations with other providers in the locality if they were unable to access this practice during the week.

People in vulnerable circumstances who may have poor access to primary care

The practice had put in place safeguarding systems which sought to protect vulnerable adults from harm.

There were arrangements in place to ensure that the needs of people in vulnerable circumstances who may have poor access to primary care were met, and there were effective joint working arrangements in place.

There was evidence of engagement with carers and staff described how they involved carers in people's care and treatment.

The practice had identified those patients who were living with a learning disability and they received an annual medical check from the Health Care Assistant and GP.

People experiencing poor mental health

The practice was effective and responsive to the needs of people experiencing poor mental health. Annual health checks were conducted and appropriate referrals were made to specialist services. Information about patients who were experiencing very poor mental health was shared with the provider of out of hours care to ensure effective joined up working.

Summary of findings

What people who use the service say

We spoke with 13 patients during our inspection. We also spoke with representatives from two care homes where patients were registered at the practice and a member of the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided. They praised the clinical and non-clinical staff, and told us that they were able to get an appointment when they needed one. We were told that timely and appropriate referrals were made when these were required.

We arranged for patients to complete our comment cards asking for their views on the practice. We reviewed 26 comment cards that had been completed by patients who visited the practice. A majority of the feedback received was positive, with clinical staff being praised for delivering a good service. Patients felt that they were treated with respect by staff at the practice. Although patients acknowledged the changes of the GPs working at the practice, they said that their care had remained excellent. Patients also found the environment to be clean, they felt listened to and three patients said that it was easy to obtain an appointment. We received five negative comments but these did not identify any common themes or common areas of concern.

Areas for improvement

Action the service MUST take to improve

- The practice must complete the actions identified in the infection control audit to ensure that patients are protected against the risk of acquiring an infection during their visit to the practice.
- The systems, processes and practices in place to keep people safe in respect of medicines management must be improved to ensure that medicines are stored at the correct temperatures.
- The practice must improve the systems used to monitor quality and improvements, namely clinical audits.

Action the service COULD take to improve

- The practice could improve the system for ensuring learning or action had been taken as a result of complaints raised.
- The arrangements for obtaining patient's consent with regards to information sharing could be improved.

Good practice

Our inspection team highlighted the following areas of good practice:

- A healthcare assistant with appropriate training was deployed to carry out blood tests in patients' homes.
- The lead partner GP and a nurse practitioner were trained and used the Cardiff Questionnaire to review the health needs of patients with learning disabilities. The Cardiff Questionnaire is a means which seeks to ensure that patients with a learning disability obtain equal access to healthcare.

Castle Gardens Medical CentreCastle Gardens Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a lead inspector and a GP, a practice manager, two further inspectors from the Care Quality Commission and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses primary medical care services.

Background to Castle Gardens Medical Centre

Castle Gardens Medical Centre provides primary medical care to approximately 8,700 patients living in Colchester.

At the time of our inspection, there were two GP partners and three salaried GPs employed at the practice.

The practice is a GP training practice and there was one GP registrar working at the practice. A GP registrar is a qualified doctor who wishes to pursue a career in general practice.

Appointments were available in the morning and afternoons. During the week, the surgery offered extended appointment times to meet the needs of the practice population. The practice was open one Saturday morning per month.

The practice was in the process of merging with two other surgeries in the local area. At the date of our inspection, these were being run as separate entities although management staff worked across all three sites.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

We carried out an announced inspection of Castle Gardens Medical Centre on 29 May 2014. The inspection was led by a lead inspector and a GP, a practice manager, two further inspectors from the Care Quality Commission and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses primary medical care services.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about Castle Gardens Medical Centre. We reviewed national data about the demographic of the practice population. We also considered data which related to the performance of the practice against national

Detailed findings

indicators. We spoke with care homes in the area whose residents used the practice and a member of the PPG. The patient participation group promoted and supported the views of patients who attended the practice.

During our visit, we spoke with a range of staff including GP partners, a GP registrar, a healthcare assistant, nurse, management staff as well as reception and administration staff. We spoke with patients who were visiting the practice and observed how staff interacted with them. We spoke with carers and/or family members. We looked at documentation, for example policies, procedures and audits that had been provided by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service. During our inspection we spoke with 13 patients and reviewed 26 of the comment cards we had left at the practice for completion by patients.

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

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Are services safe?

Summary of findings

We found that improvements were needed to ensure that the service is safe.

The systems, processes and practices in place to keep people safe in respect of medicines management and infection prevention and control were not effective. The infection control audit had not been actioned and there was no risk assessment to identify and control the risk of infection. Temperatures of fridges used to store medicines could not be assured. We have identified these as a breach of regulation.

The practice had policies in place that promoted staff to be open and transparent and we saw an example of this policy being used in practice.

We saw that the practice analysed and learnt from significant events although there were some gaps in the recording of these.

Our findings

Safe patient care

We saw that the provider recorded some significant events. However, there were no clear arrangements or written protocols for the formal reporting of incidents and we could not be assured that all incidents were reported or managed effectively. Staff told us that adverse events were reported verbally to the lead GP, who recorded and investigated the event. We were informed of one significant event in detail but we could not find any record of this.

We found that the practice had arrangements in place which sought to ensure that it met health and safety requirements. A recent fire evacuation had been completed safely and action had been taken to safeguard personal records in response to fire testing. Fire checks had been completed although there were some gaps in the frequency of these tests. Contracts were in place for services that supported the safe running of the practice, including waste management and shredding of confidential documents.

Learning from incidents

The practice had two policies in place that encouraged staff to be open and transparent: a blame free culture policy which encouraged staff to report incidents, and a being open policy which promoted openness following any medical incidents. We saw an example of this policy being used in practice, whereby a member of staff immediately reported a clinical incident. The incident was investigated and appropriate action was taken.

We saw that the provider analysed and learnt from significant events. Evidence showed the learning and improvements that had been made as a result of the event.

Safeguarding

The practice had arrangements in place to ensure that patients were safeguarded against the risks of abuse. We saw evidence which confirmed that staff had received training about protecting children and vulnerable adults from abuse. Staff we spoke with were knowledgeable about the procedures that were in place, and gave examples of where safeguarding concerns had been raised. We saw that contact details for the local safeguarding authorities were displayed in the reception area so that staff knew who to contact in the event of an alert.

Are services safe?

There was a safeguarding policy which advised staff of who to speak with in the event that they had a concern. There was a nominated safeguarding lead at the practice to ensure that effective procedures were followed. There was evidence that the safeguarding procedures were implemented appropriately.

Monitoring safety and responding to risk

A member of the administration team was responsible for summarising patients' records. These were checked by the clinicians and audited by the registered manager to ensure that patients' records were an accurate and informed clinical record. We noted that read codes (the electronic clinical encoding of people's medical history and background) were completed consistently to ensure that clinicians were aware of people's health needs.

National prescribing alerts were disseminated to all GPs and nurses. Prescribing alerts inform clinicians when there is an immediate concern with a medicine. We were told that, where relevant, a search was carried out of the computer system to identify any affected patients and necessary action was taken to minimise possible risk.

Medicines management

A member of staff told us that concerns had previously been raised about prescriptions getting lost when these were sent to the pharmacy for collection. They showed us a system that the administration team had devised to record when a prescription had been collected by the pharmacy. This ensured that there was an audit trail of the individual prescriptions to ensure that these could be managed safely.

Repeat prescriptions could be ordered either at the practice or online. People we spoke with told us that they found that repeat prescriptions were generated in a timely manner. The practice had procedures in place to ensure that patients who had found it difficult to go to the practice in person were able to obtain their prescriptions efficiently. For example, GP or practice nurse would periodically attend at the care homes where patients lived in order to review and produce repeat prescriptions. This was to ensure that prescriptions were generated when required.

We found that not all medicines were stored safely. There were two fridges that were used to store medicines. One of the fridges was unlocked and could have been accessed by members of the public.

Both fridges were used to store vaccines. We saw that the temperatures of both fridges were recorded daily, and these were within the required parameters of two degrees Celsius to eight degrees Celsius. The required temperatures are detailed in the protocol for ordering, storing and handling vaccines, Public Health England, March 2014.

The display on the main fridge recorded the minimum and maximum temperatures of the fridge, although this was not the case for the smaller fridge, which only recorded the actual temperature at any time. The recording of maximum and minimum temperatures is advised as fridge temperatures can vary considerably.

On the main fridge, the display recorded that the minimum temperature of the fridge had been as low as one degree Celsius. The maximum temperature recorded was 22 degrees Celsius. As the fridge temperature should have been between two and eight degrees Celsius, this meant that the integrity of the vaccines could not be assured.

The staff at the practice were unclear as to who was responsible for taking the fridge temperatures. It was unclear when the fridge had breached the required temperatures as the display had not been monitored. There was no protocol for the storage of the vaccines or what should be done when an adverse temperature was recorded to ensure the integrity of the medicines. Therefore, the issue was may not have been rectified as soon as possible in order to minimise the risk to patients who needed the vaccines that were being stored.

We were informed by a member of the management team that there had been an occasion in the past whereby all vaccines had to be destroyed due to inadequate storage at the practice. This suggested that the practice had not learnt lessons when this error had occurred in the past. The practice did not protect patients from the risks associated with the unsafe use and management of medicines as the arrangements in place to record and store medicines were not effective.

Cleanliness and infection control

We found that clinical areas and communal areas were clean. However, the systems in place to assess the risk of and prevent, detect and control the spread of infection were not effective. This was because although an infection prevention control audit had been completed in April 2013, no action plan had been completed to ensure that required

Are services safe?

improvements were made. The practice told us that they were aware that the action plan had not been completed in response to the audit and they were in the process of addressing this.

The infection prevention control audit identified that there was no risk assessment in place for the prevention and control of infection. Further, environmental cleaning checklists were not complete or up to date. We saw that this was still the case. We spoke with a member of clinical staff who had some cleaning responsibilities. They were unsure who should be auditing the checklists to ensure that these were complete. They told us that they thought that the daily contract cleaners would benefit from a schedule as some areas were not clean as they should be.

Staffing and recruitment

We saw evidence to confirm that there were sufficient numbers of suitably qualified and skilled staff employed at the practice to meet patients' needs. Patients we spoke with told us that the practice was well-staffed and that clinical staff were recruited when a need was identified. We spoke with a member of the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided. They told us that the practice had been through a careful selection process to recruit the right staff.

A healthcare assistant with appropriate training was deployed to carry out blood tests in patients' homes. It was identified in staff meeting minutes that this would reduce requests for other clinical staff to conduct home visits.

Dealing with Emergencies

Practice meeting minutes showed that changes in circumstances that could affect the safety and effectiveness of the service were discussed. This included changes in staff, the impact of the proposed merger with two other surgeries in the area and extreme weather conditions.

Equipment

The servicing and calibration of equipment, including clinical equipment, was completed in a timely manner. We were told that portable appliance testing was due to be completed in the week preceding our inspection although this was cancelled due to unforeseen circumstances but was in the process of being rearranged. This meant that there were systems in place with regards to the use and maintenance of the equipment and premises to ensure that people were safe.

We found that there were sound protocols in place to support the use of the emergency equipment in the event that a patient needed immediate first aid or life-support. There were adequate supplies of emergency equipment available. This was clearly labelled and could be easily accessed in the event of an emergency.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found that improvements were needed to ensure that the service is effective.

There was a lack of clinical audit. This meant that the practice had not effectively identified and responded to data which indicated clinical shortfalls. This meant that appropriate remedial action may not have been taken if this was required. We have identified this as a breach of regulation.

Care and treatment was delivered in line with current published best practice.

The practice positively engaged and worked in partnership with other services to meet the needs of patients. Staff received training that was appropriate to their role.

Health promotion advice was displayed in the waiting room and near to the reception desk for patients and carers. Patients told us that the GPs provided advice to support them to manage their own health needs.

Our findings

Promoting best practice

We were informed by the lead GP partner that all of the GPs met every Friday. Minutes showed that these meetings were used to discuss significant events, complaints, areas for improvement and training. A representative from reception would attend these meetings every month, as would the lead nurse. This was confirmed by staff with whom we spoke.

We found that National Institute for Care and Health Excellence (NICE) guidance was used by GPs and nurses, accessed from the internet. This was intended to ensure that assessment, care and treatment was delivered in line with recognised standards.

The practice had been awarded the Gold Standards Framework (GSF) accreditation for excellence in end of life care and was one of the first surgeries in the county to receive this award. The GSF is a nationally recognised multi-agency approach to palliative care. It advocates more engaged discussions about people's end of life care to enable people to die in their preferred place and for more families to receive bereavement support.

Management, monitoring and improving outcomes for people

Prior to our inspection, we obtained data which identified that the practice had a higher level of prescribing non-steroidal anti-inflammatory drugs (NSAIDS), a type of pain relief medicine, than the national average. The lead GP partner was able to give us a satisfactory explanation for this anomaly.

Data identified that people in the Essex area are more likely than average of having a long term health condition or health related problems in daily life. Data also indicated that the practice had a poorer rate than average of referring people to specialist services when they were suspected of having cancer and a higher rate of emergency admissions when people had diabetes or Chronic Obstructive Pulmonary Disease (COPD). We were informed by the lead GP partner that he was unsure why this was the case, as there was a good team at the practice. He told us that the practice had not completed clinical audits within the last 6-12 months to track pathways of care and identify possible reasons for this data. This meant that appropriate remedial action may not have been taken if this was required.

Are services effective?

(for example, treatment is effective)

The systems used to monitor quality and improvement were unclear. We found that the practice staff had previously undertaken a range of audits, including audits of referrals and a child safeguarding audit. There was no audit policy or plan in place and most job descriptions did not make reference to staff responsibilities for audit.

We found that the practice performed well across all other national quality indicators which were used to assess how well the practice was performing.

Staffing

Staff we spoke with confirmed that they had received induction training when they started their job. This included reviewing the practice's policies and procedures, followed by shadowing a more experienced member of staff.

There was one GP registrar employed at the practice. These are qualified doctors who wish to pursue a career in general practice. We saw that there were effective systems in place to support and supervise them. They told us that they felt supported at the practice and that, although they had a designated GP trainer, that they found all of the GPs to be approachable.

Job descriptions were in place for most staff roles. However, these had not been recently reviewed and did not always reflect current working practice. It was anticipated that these would be updated as part of the merger process. Similarly, we found that person specifications, which set out the qualifications and experience required for an individual to undertake certain roles, were either not present or did not reflect the member of staff's current role.

We found that some staff records were inconsistent and that there were gaps in the documentation. We looked at four staff records, three of which had been appointed in the last year. In two files there were no references, and in another two there were no interview records.

We were informed by a member of the management team that the training they required of staff included fire safety, infection prevention control and safeguarding vulnerable adults and children. However, there was no training policy in place that determined which training staff should complete to ensure that they were competent in their role. Staff were given time during working hours to complete their training, or alternatively, they were paid to complete this at home. Staff confirmed they had completed this training.

Practice meeting minutes showed that external courses and educational meetings were highlighted to staff on occasions.

Working with other services

We found that the practice positively engaged and worked in partnership with other services to meet the needs of patients. Palliative care meetings, involving a Macmillan nurse took place once a month to promote effective joined up working in the community. The practice worked with the local care advisor, who provided advice, support, information and assistance to vulnerable people in their own homes on subjects such as welfare benefits, access to social care and support to maintain their independence.

Representatives from care homes that we spoke with in the area told us that they had a good working relationship with the practice and confirmed that the GPs attended their services to complete people's yearly reviews to check their general health and review their medication.

There were protocols in place to share information with providers about patients who received out of hours care and treatment. The practice provided information to the out of hours service about patients who were considered to be more likely to require the use of out of hours services, such as patients receiving end of life care or patients with severe mental health needs. Information about the treatment given and diagnosis determined at the out of hours appointment was received into the practice promptly. This information was assigned to the patient's GP for relevant action. These arrangements were intended to ensure that relevant information was shared so that patients experienced a consistent delivery of care.

Health, promotion and prevention

The new patient registration pack included information about NHS summary care records and a practice information leaflet. This leaflet gave details of the GPs, clinical staff and receptionists and the services and clinics available at the practice. This information was also available online.

Health promotion advice was displayed in the waiting room and near to the reception desk. We found information displayed for carers and how they could access additional support and maintain their own health. Information was also displayed about health promotion services, for example, weight management courses and

Are services effective?

(for example, treatment is effective)

smoking cessation advice. The practice offered specific clinics for patients whose needs included asthma, coronary heart disease, stopping smoking, weight control and diabetes.

A patient told us that the GP spoke with them about the importance of healthy eating and exercise for maintaining a healthy blood pressure, to enable them to manage their own health and wellbeing.

Are services caring?

Summary of findings

The service was caring.

Patients we spoke with told us that staff involved and treated them with compassion, kindness, dignity and respect. We observed sensitive, discreet interactions between patients and reception staff.

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were treated with dignity and respect. We observed sensitive, discreet interactions between patients and reception staff. As the reception desk was open, staff told us that they did not use patients' names when they were discussing personal confidential information. We noted this was the case during our observations.

Staff informed us how sensitive information was disseminated to relevant personnel to ensure that it was discussed considerately and confidentially. For example, they told us how the GPs came to speak with them to inform them of a person who would prefer to be addressed by a name other than their given name. We were advised of how bereavements were handled with staff to ensure that the patient's family was responded to compassionately and appropriately. The details of bereavements were recorded on a board placed discreetly in the reception area so that all staff were aware of patients' circumstances. Leaflets about support during bereavement were available in the waiting area.

Information about the availability of chaperones was displayed in the waiting area. Chaperone training had been identified as an urgent requirement in meeting minutes dated October 2013. At the time of our inspection this training had not been implemented. It was unclear when this was due to take place. However, we found that action had been taken to ensure that only staff who were appropriately experienced acted as chaperones.

Involvement in decisions and consent

Patients told us that they were involved in decisions about their care and treatment. They told us that GPs listened to their concerns and explained the treatment options available to them.

Staff were aware of the importance of obtaining consent. We observed reception staff obtaining prior consent from the patient before disclosing test results to a relative.

Powers of Attorney forms were recorded at the beginning of the patients' notes so that the clinician knew who was legally authorised to give consent on behalf of a patient. Do not attempt resuscitation (DNAR) forms were stored in a prominent position so that these could be accessed quickly

Are services caring?

if required. A GP informed us that they worked in the best interests of patients who the lacked mental capacity to make decisions about their care and treatment, involving a patient's carers and family when appropriate.

The practice worked closely with a local service which offered support to people who were homeless. We were informed that the practice received a fax from a nurse at the service which offered support to people who were homeless. The fax explained the person's health needs. This was then followed up during an appointment with the GP. We were informed that the GP would then fax details of the consultation back to the nurse from the service. As there was no consent obtained from the person who attended the practice to inform the service of the outcome of their appointment, this was not an appropriate disclosure. This was acknowledged, at the time of our inspection, by the management team who informed us that they would be taking steps to obtain the appropriate consent.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to people's needs.

The practice understood the needs of the patient population and made reasonable adjustments to meet those needs.

The practice offered extended opening hours so that patients were able to attend the practice when they needed to.

Complaints were responded to in a timely manner.

Our findings

Responding to and meeting people's needs

The practice understood the needs of the patient population and made reasonable adjustments to meet those identified needs. The practice was accessible to patients in vulnerable circumstances who may have had poor access to primary care. The practice completed annual health checks for patients, with learning disabilities, living in a local care home. The lead partner GP and a nurse practitioner were trained and used the Cardiff Questionnaire to review the health needs of patients with learning disabilities. The Cardiff Questionnaire is a means which seeks to ensure that patients with a learning disability obtain equal access to healthcare.

We spoke with representatives of two care homes that the practice visited. Both were very positive about Castle Gardens Medical Centre. One representative explained that a nurse practitioner from the practice visited people at the home three times a week. They told us that a GP from the practice would visit the home if they were passing to check that everything was OK. The other representative that we spoke with gave very positive feedback, and told us that their residents had good access to the practice.

The practice had access to a translation service, The Big Word, which also provided cultural context to given health issues. We were informed that this was not used often, as people who did not speak English would usually be accompanied by a relative who communicated on their behalf. We were advised that some clinical staff were able to speak other languages should the need arise.

Access to the service

Patients told us that they felt listened to and found it easy to obtain an appointment.

We saw that home visits and telephone consultations were available for patients who were unable to access the practice. Appointments could be booked over the telephone and also online.

The practice offered extended opening hours so that people were able to attend the practice when they needed to. We received positive feedback from patients about the efficiency of the appointments system. Patients told us that they were able to get an appointment at short notice if this was required. Information was displayed in the waiting

Are services responsive to people's needs?

(for example, to feedback?)

room advising of Saturday morning drop in clinics with other providers where children under the age of 18 could receive their immunisations if they were unable to access their practice during the week.

Information was displayed in the waiting area about cervical screening. We were informed by staff that GPs would conduct cervical smear tests during the extended practice hours if women required an appointment when a member of nursing staff was not available. Female patients we spoke with confirmed that they were able to get an appointment with a female GP should they request this.

Concerns and complaints

There was a complaints policy available at the practice. Information was also published on the practice's website, which detailed where to find the complaints policy. In the event that a complainant was dissatisfied with the outcome of their complaint, they were advised to contact the Public Health Service Ombudsman.

We reviewed the records of 11 of 15 complaints that had been received since March 2013. These demonstrated that the practice replied promptly, usually within two days. If appropriate, complainants were offered a follow up appointment with the GP to discuss their complaint.

Records did not always identify what learning or action had been taken as a result of the complaint. Further, with regards to one of the complaints raised, we saw one instance whereby a GP responded to an email complaint from a patient's relative without obtaining the patient's agreement to share their information. This meant that confidential information may have been shared without the patient's knowledge or agreement. The practice had not identified this risk.

Are services well-led?

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

Summary of findings

The service was well-led.

The lead GP was supported by a management team. This sought to ensure that there were clear governance arrangements and leadership in place.

There were mechanisms in place to encourage, hear and act on feedback from staff. Staff attended regular meetings at the practice. Meeting minutes evidenced that they were involved in the day-to-day and long term visions of the practice.

Practice education meetings occurred monthly to enable clinical staff to partake in shared learning and improvement.

Our findings

Leadership and culture

On the date of our inspection, Castle Gardens Medical Centre was in the process of merging with two other practices. This was being well managed by the lead GP and other senior staff across the merging organisations. Prior to the decision to merge, the practice had been through a period of uncertainty that had posed a possible threat to its leadership. This was due to changes of key staff, such as GP partners and the practice manager. In consideration of this and the needs of the practice population, plans were devised to merge with two other local GP practices. This proposed merger is due to complete in April 2015.

Governance arrangements

The practice was led by a partner GP. There was a management structure that had recently been put in place with a view to effectively handling the proposed merger. The management personnel each had responsibly for governance as relevant to their job title. The management team consisted of an operations manager, office manager, business manager and finance manager. All but one of the management team worked across all three practices to ensure shared practice and continuity.

Systems to monitor and improve quality and improvement

We found that protocols and policies were under-developed and some required review. The practice was aware of this area for development and a project was in progress developing an electronic library of policies that could be signed by staff to acknowledge their awareness. A number of policies had been completed and were available for staff to review. Others were absent, including policies for managing medical emergencies and summarising records.

Patient experience and involvement

There was an active patient participation group (PPG) that met quarterly. The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided. The meetings were chaired by a GP or manager from the practice. We were informed by a member of the PPG that the chairperson listened to any concerns that were raised, although they were usually taking action to deal with any issues before

Are services well-led?

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the PPG concerns had been voiced. We did note from meeting minutes that, although the PPG had suggested redecoration of the waiting area in 2013, as of the date of our inspection no action had been taken.

Staff engagement and involvement

Staff were encouraged to be open and transparent. This was reflected in the practice's policies and procedures, including a whistleblowing policy that staff signed to acknowledge.

Meeting minutes evidenced that staff were involved in the day-to-day and long term visions of the practice. Practice meetings took place every two weeks and staff who attended were able to influence the agenda of future meetings. We saw that staff were actively engaged and involved in the continued organisation of the practice. Staff that we spoke with told us that they felt listened to and explained how their suggestions had been successfully implemented by the management with their continued input.

Staff demonstrated a clear vision for the potential impact of the proposed merger with two other practices that was due to take place in April 2015. Meeting minutes evidenced that this has been effectively communicated from an early stage in the process to ensure that staff were consulted appropriately.

Learning and improvement

Appraisals were to be completed annually, although no appraisals had been completed during 2013/2014. The management team were aware of the delay in the delivery of the appraisals and they were seeking to address this issue. This meant that staff may not have had clear objectives focused on improvement in line with the practice's vision and values.

All GPs completed an appraisal and 50 hours of continuing professional development each year.

The senior GP partner attended external professional meetings, for example a drugs and alcohol study day. He also attended the North East Essex medicines management committee and worked closely with the prescribing team.

Practice education meetings occurred monthly and these were attended by clinical staff. We found that in these, significant events were discussed and relevant changes implemented. For example, we saw that following a medical emergency, additional training was put in place for reception staff. Minutes showed that clinical topics and individual complex patients were discussed. These meetings had a clinical focus and minutes demonstrated that learning was shared.

Identification and management of risk

Senior staff described clearly the risks of the merger including areas of the practice which required improvement. They also described how resources would be shared across the three practices moving forward. For example, this included the consolidation of policies and procedures which had been identified as requiring update and review. Further, they had identified where internal referrals could be made to GPs with specialist interest, such as dermatology, cardiac and substance misuse which sought to ensure positive outcomes to patients.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

There were effective processes in place to ensure that, in the event that an older person lacked mental capacity, the clinician knew who was legally authorised to give consent on their behalf for decisions which related to their health and welfare.

Representatives from care homes for older people who we spoke with told us that the practice was caring and treated patients with dignity and respect. The practice was responsive to the needs of older people.

Older patients who were unable to access the community were in the process of being identified on the patient record system by a computer code so that proactive support and advice could be offered.

Our findings

There were effective processes in place to ensure that, in the event that an older person lacked mental capacity, the clinician knew who was legally authorised to give consent on their behalf for decisions which related to their health and welfare. This was because details of patients' designated representative were recorded at the beginning of the patient's notes as relevant. A GP informed us that they would involve the patient's carers and family when they lacked mental capacity and work in the best interests of said patients. This demonstrated a working awareness of the Mental Capacity Act.

The practice was responsive to the needs of older people. Patients in care homes were able to access services in a timely way as an advanced nurse practitioner visited larger care homes three times a week. The local Clinical Commissioning Group was monitoring the effectiveness of this arrangement and was keen to replicate this approach in other surgeries. Representatives from care homes who we spoke with told us that the practice was caring and treated patients with dignity and respect.

The provider worked with the local care advisor, who provided advice, support, information and assistance to vulnerable people in their own homes on subjects such as welfare benefits, access to social care and support to maintain their independence.

Older patients who were unable to access the community were in the process of being identified on the patient record system by read code so that proactive support and advice could be offered. A read code is the clinical encoding of people's medical history and background.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

There were systems in place which sought to ensure that people who had long-term conditions were kept safe.

The provider was unable to give explanations for negative trends identified in statistical data. This was because service had not maintained an effective clinical audit cycle.

Patients with long-term conditions told us that the practice was caring and helpful and that support was also given to their carers.

Multi-agency palliative care meetings were held monthly. Palliative care is the care given to relieve the pain, symptoms and stress of patients at the end of their life. These meetings were attended by community matrons, Macmillan nurses and care home staff. The practice had been awarded the Gold Standards Framework (GSF) accreditation for excellence in end of life care and was one of the first surgeries in the country to receive this award. The GSF is a nationally recognised multi-agency approach to palliative care.

Our findings

There were systems in place which sought to ensure that patients who had long-term conditions were kept safe. National prescribing alerts were disseminated to all GPs and nurses. Where relevant, a search was carried out of the computer system to identify any affected patients and necessary action was taken to minimise possible risk.

GPs carried out routine checks for patients with asthma, coronary heart disease and diabetes to monitor patients with long-term conditions. We found that NICE guidance was used by GPs and nurses, accessed from the internet which was intended to ensure that assessment, care and treatment was delivered effectively and in line with recognised standards.

Data indicated that the practice had been identified as having a poorer rate than average of referring people to specialist services when it was suspected that they were suspected of having cancer and a higher rate of emergency admissions when people had diabetes or Chronic Obstructive Pulmonary Disease (COPD). We were informed by the lead GP partner that he was unsure why this was the case, as there was a good team at the practice. He told us that the practice had fallen behind on completing clinical audits to track pathways of care and identify possible reasons for this data. This meant that appropriate remedial action may not have been taken if this was required.

We found that do not attempt resuscitation (DNAR) forms were stored in a prominent position so that these could be accessed quickly if the patient was in a situation where resuscitation was being considered.

Patients with long-term conditions told us that the practice was caring and helpful and that emotional support was also given to their carers.

Multi-agency palliative care meetings were held monthly, attended by community matrons, MacMillan nurses and

People with long term conditions

care home staff. At these meetings, individual patients with palliative care needs were discussed. Information about patients receiving end of life support was shared with provider of out of hours care to ensure effective joined up working.

The practice had been awarded the Gold Standards Framework (GSF) accreditation for excellence in end of life care and was one of the first surgeries in the county to receive this award. The GSF is a nationally recognised multi-agency approach to palliative care. This demonstrated that the service provided for people with long-term conditions was well-led.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice had put in place safeguarding systems which sought to protect children from harm. Children received childhood vaccinations in line with the national NHS vaccination schedule and the Healthy Child Programme.

The practice was responsive to the needs of mothers, babies, children and young people. Information was displayed in the waiting room advising of Saturday morning drop-in sessions at other clinics. This was where children under the age of 18 could receive their immunisations with other providers in the locality if they were unable to access this practice during the week.

Our findings

The practice had put in place safeguarding systems which sought to protect children from harm. Staff had received training in safeguarding children and demonstrated a good knowledge of what they would do if they suspected a child was at risk of abuse. There were policies in place for safeguarding children. Disclosure and Barring Service checks had been undertaken before staff began to work at the practice to ensure staff were suitable to work with children.

Children received childhood vaccinations in line with the national NHS vaccination schedule and the Health Child Programme. We saw that information was displayed in the waiting room advising of Saturday morning drop in clinics where children under the age of 18 could receive their immunisations with other providers in the locality if they were unable to access the practice during the week.

The lead GP told us that he routinely gave parents of unwell children written prompts to alert them to any potential deterioration in their child's condition. He described an incident when this had enabled a mother to understand that they needed to bring their baby back to see the GP when the baby became acutely unwell.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice was responsive to working age people. Appointments were available earlier in the mornings and later in the evenings to make appointments more accessible to working age patients.

Appointments could be booked online the evening before the consultation was required which sought to ensure that patients could achieve and maintain good health whilst they fulfilled their employment obligations.

Our findings

The service was responsive to working age people. Appointments were available earlier in the mornings and later in the evenings to make appointments more accessible to working age patients.

Appointments could be booked online the evening before the consultation was required which sought to ensure that patients could achieve and maintain good health whilst they fulfilled their employment obligations.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

The practice had put in place safeguarding systems which sought to protect vulnerable adults from harm.

There were arrangements in place to ensure that the needs of people in vulnerable circumstances who may have poor access to primary care were met, and there were effective joint working arrangements in place.

There was evidence of engagement with carers and staff described how they involved carers in people's care and treatment.

The practice had identified those patients who were living with a learning disability and they received an annual medical check from the Health Care Assistant and GP.

Our findings

The practice had put in place safeguarding systems which sought to protect vulnerable adults from abuse. This included a safeguarding policy which advised staff of who to speak with in the event that they had a concern.

Evidence showed that potential risks to people who had poor access to primary care were identified and communicated effectively. There was a protocol in place for working with a service that provided support for people who were homeless. The protocol identified that the practice would fax details of the consultation with the person back to the nurse from this service. As there was no consent obtained from the person who attended the practice, this was not an appropriate disclosure. We discussed this with the practice and they advised us that they would ensure that patients would be asked for their consent in the future. They told us that this consent would be recorded.

There was evidence of engagement with carers. A carers' policy was in place that defined carers, promoted their identification and set out ways of supporting them. The support offered included a flexible approach to appointments, physical help in the car park and waiting room, an annual health check and flu vaccination. A practice carers' lead was identified and a poster and referral form had been developed.

The lead partner provided a prescribing service for people who had an addiction to illegal drugs. There were appropriate joint working arrangements in place with local drug and alcohol services to support the treatment of addiction. This was supported by a shared care agreement for Methadone prescribing. The pharmacist, key worker and patient were all involved in this process.

People in vulnerable circumstances who may have poor access to primary care

People with a disability may not have always been identified as there was no disability register in place. We were told that 'significant' disabilities were recorded on the front page of people's electronic records, but it was unclear how this was identified. The lead GP partner acknowledged that this was an area for improvement.

There was a register of people with learning disabilities in place. People with a learning disability received an annual medical check from the health care assistant and GP. Staff had recently received learning disabilities training. The lead GP and a nurse practitioner were trained and used the Cardiff Questionnaire to review the health needs of patients with learning disabilities. The Cardiff Questionnaire is a means which seeks to ensure that patients with a learning disability obtain equal access to healthcare.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice was effective and responsive to the needs of people experiencing poor mental health. Annual health checks were conducted and appropriate referrals were made to specialist services. Information about patients who were experiencing very poor mental health was shared with provider of out of hours care to ensure effective joined up working.

Our findings

We spoke with a representative from a residential service that provided support for people experiencing poor mental health. They told us that the practice was very helpful and that patients were visited by a GP if required. The representative said that they could speak with a GP in an emergency. They explained that the practice conducted annual health checks for patients who lived at the service.

A patient that we spoke with told us that they and their relative had received very good support from the practice when their relative was experiencing a period of poor mental health. They told us that appropriate referrals were made so that their relative could receive cognitive behavioural therapy (CBT).

Information about patients who were experiencing very poor mental health was shared with provider of out of hours care to ensure effective joined up working.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	There were not reliable systems, processes and practices in place to keep people safe in respect of medicines management. We have identified this as a breach of Regulations 13.

Regulated activity	Regulation
	There were not reliable systems, processes and practices in place to keep people safe in respect of infection prevention and control. We have identified this as a breach of Regulations 12 (2)(a) & 12 (2)(c)(i)

Regulated activity	Regulation
	The systems used to monitor quality and improvements were not effective. There was a lack of clinical audits and policies and protocols required development. We have identified this as a breach of Regulation 10 (1)(a) & (b).