Colne Medical Centre

Quality Report

40, Station Road
Brightlinsea,
Essex,
CO7 0DT.
Tel: 01206 302522
Website: www.colnemedicalcentre.nhs.uk/index.aspx

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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

Colne Medical Centre provides primary medical services to people in the town of Brightlingsea and the surrounding areas. There is a branch surgery which provides primary medical services to people in the village of Alresford and the surrounding areas. The branch surgery has a dispensary on site to issue medications to patients.

We found the practice was safe, effective, caring, well-led and responsive. The practice had arrangements to provide health care services for older people (over 75s), people with long-term conditions, mothers, babies, children and young people. There were services for people in vulnerable circumstances who may have poor access to primary care and people experiencing a mental health problem. The practice did not feel they needed to provide specific services for the working age population and those recently retired (aged up to 74).

We spoke with 17 patients during our inspection. They gave us positive comments regarding the care and treatment they had received. We received positive comments from six patients registered at the practice on comment cards we had left for completion by those attending the practice.

The practice had a management structure that ensured the smooth running of the services provided. Staff told us that they felt supported and valued. There were systems in place that identified relevant legislation, latest best practice and evidence based guidelines and standards which contributed to effective patient care. The practice carried out clinical audits to check the quality of clinical care provided.

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 the service was safe.

People gave us positive comments about their care and told us they felt safe.

There were systems in place to support the staff working at the practice and keep the patients using the service safe. Root cause analysis of incidents and learning points identified prompted changes to procedures within the practice when needed.

Safeguarding guidance, contact details and referral information to the local social services safeguarding team was current and referral details were up-to-date.

Risks to patients were assessed before care and treatment was commenced. Documentation used showed health checks were performed and risks were explained to patients before their treatment to ensure safe patient care.

There was a range of standard operating procedures (SOPs) in use by the dispensary staff for guidance. SOPs are written work processes that explain a procedure from start to finish; these processes were regularly reviewed and up-to-date.

The practice and the branch surgery were visibly clean in all areas on the day of inspection.

We viewed equipment used for monitoring chronic disease management at the practice and saw that, where required, this had been annually calibrated in line with manufacturer's guidelines. The emergency equipment was also regularly checked, any accessories used were in date, and appropriate for emergency use.

Are services effective?

The service was effective.

The registered manager told us to promote best practice, that access to the internet was available and used by all the clinical staff at the practice to identify relevant legislation, latest best practice, and evidence based guidelines.

The commitment by the practice to provide good quality of care, and to recall and monitor chronic disease at the practice was seen in the improved quality outcomes figures (QOF). QOF is a system to

Summary of findings

reward general practices to provide good quality care to their patients, and to help fund work to further improve the quality of health care delivered. This information is published annually about practices regarding clinical quality and is available to access.

Within the area of staffing, the induction process for newly recruited members of staff was effective and appropriate for their roles. Staff received training necessary for their role in the practice.

The practice referred patients appropriately to and supported the work of a health trainer who held a clinic at the practice. A health trainer is somebody trained to help with behaviour change and to provide motivational coaching in order to help achieve long-term lifestyle goals.

When new patients registered at the practice they were invited to attend a new patient consultation where information was gathered on health and lifestyle with the health care assistant. This appointment was used to give health promotion information to patients, and information about the services available in the local community.

Are services caring?

The service was caring.

People we spoke with who were visiting the practice during the inspection were positive about the attitude of the staff and how they were treated. During the inspection we saw how staff responded to patients and patient's relatives in a manner that showed compassion and understanding.

People told us, they felt involved in decisions, that different options were discussed, and they had consented, to their care and treatment.

Are services responsive to people's needs?

The service was responsive to people's needs.

All the patients we spoke with preferred the choice of a morning open surgery option to access the practice for a consultation quickly and a bookable appointment system in the afternoon if the appointment was not urgent. The appointment system at the practice was set up to accommodate this preference.

The practice responded to complaints in line with their own procedure.

Are services well-led?

The service was well-led.

Summary of findings

We saw the practice held regular meetings which included all staff members to discuss the day to day business of the practice.

There was a comprehensive intranet that contained policies, procedures and clinical guidelines for staff use. The practice encouraged, patient's views and had forms available on their website to express their opinion.

We saw appraisals took place annually, these were documented and signed to show that they were agreed.

Risks and hazards were recognised and assessments were carried out to protect staff at work and people visiting the practice.

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
The practice had systems to identify and visit older people that were unable to leave their home or in a care home to ensure they had regular access to a GP or a nurse to ensure their health and wellbeing. These visits enabled clinicians to review medication, treatment, and care, including mental and physical health checks.

People with long-term conditions
There were systems in place to monitor those patients with long term conditions and offer them follow-up reviews to maintain their health optimum.

The practice had arrangements to care for patients with on-going health problems and to support their carer's. There were links with community nurses and palliative care nurses to ensure complete care.

The practice ran clinics to manage patients with diabetes, and asthma.

Mothers, babies, children and young people
The practice had systems in place to offer co-ordinated care for this population group. We saw consent processes were appropriately applied for this group. We also spoke with the midwife that provided antenatal care at the practice and the health visiting service about the support and advice clinics they held within the practice for this population group.

The working-age population and those recently retired
The practice appointment system ensured people of working age and those recently retired could make an appointment to see a GP.

People in vulnerable circumstances who may have poor access to primary care
We were told by care homes looking after people in vulnerable circumstances for example learning disabilities they were sensitive to the needs of this group of patients when they visited the practice.

People experiencing poor mental health
The practice had a system to identify patients experiencing a mental health problem and then refer them appropriately. Services were offered with the local NHS mental health team.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for comment cards to be made available for patients to complete in order they could give us their view on the service provided. Our review of the six comments cards left by patients for us showed that people were positive about the service provided, and the standard of their care. They were also positive about the clinics provided and reported that they felt that the doctors and nurses treated them with dignity and respect.

When we spoke with patients during the inspection they were positive and satisfied with the attitude of the staff and the way they were treated. Patients told us that staff members and doctors were courteous and respectful.

Care homes that used the practice services said the receptionists passed the messages to the doctors when requested. They said the doctors talked with the patients they cared for. They said they treated patients as individuals and did not talk over them. They also told us that clinicians explained treatment and other information to patients in a manner they could understand.

Areas for improvement

Good practice

Our inspection team highlighted the following areas of good practice:

We asked the practice how they had responded to the recent closure of the local hospital phlebotomy clinics and the service move to Colchester. The practice had calculated the number of people that would be affected by the loss of this service, and increased the nursing staff level to include additional phlebotomy appointments.

Home visits called 'frailty visits' by the practice, to carry out health checks, phlebotomy, immunisations and medication reviews, were undertaken by nurses to patients who were housebound. Patients who needed these visits were discussed at meetings held regularly at the practice.

Colne Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and a GP. The team included a second CQC inspector and two other team members a practice manager and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Colne Medical Centre

Colne Medical Centre provides primary medical services for their population of approximately 9500 in the whole of Brightlingsea and its surrounding villages. It has a dispensing branch surgery at Alresford. A dispensing surgery is one where the population live remotely from a pharmacy therefore both primary medical services and pharmacy dispensing services are provided in the same location. The clinical team at the practice includes six doctors, three nurses, two pharmacy dispensers, and three health care assistants. Colne Medical Centre is a training practice which means hospital doctors that want to enter general practice spend six to eighteen months at the practice to gain the experience they need to become general practitioners.

The main Brightlingsea address is:	The branch surgery address is:
40 Station Road	1 Coach Road
Brightlingsea	Alresford
Essex	Essex
CO7 0DT	CO7 8EA

The main practice is open from 8:30am to 12:30 then 1:30pm to 6pm Monday to Friday. The branch surgery is open from 8:30am to 10:30am Monday to Friday. The practice is also open, for a three month trial period from June to August 2014 on Tuesday evenings from 4pm to 6pm for pre-booked appointments. The patients are registered at the main Brightlingsea practice and patients registered at the practice can choose to be seen at the branch surgery if that is closer or more convenient for them.

Why we carried out this inspection

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

How we carried out this inspection

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?

Detailed findings

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

- Older people
- People with long-term conditions
- 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

Before we inspected Colne Medical Centre, we reviewed a range of information we held about the service. We asked care homes and healthcare professionals that were involved with and worked with the centre, to share what they knew about the service. We carried out an announced inspection on 03 June 2014.

During our inspection we spoke with a range of staff including; two doctors, a nurse, a dispensing assistant, the practice manager and assistant practice manager, secretaries, administrative assistants and receptionists. We spoke with patients who used the practice services and talked with carers and family members. We observed how people were spoken with and cared for. We reviewed the comment cards we had provided the practice with, to enable members of the public to share with us their views and experiences of the practice's service provision. We also spoke with a member of the patient participation group (PPG). PPGs are groups of patients who have volunteered from practice populations, to form a group for patients to work together to improve services, promote health and improve quality of care for the practice they represent.

We also reviewed information that had been provided to us during the inspection and additional information which was requested and reviewed after the inspection visit.

Are services safe?

Summary of findings

The service was safe.

People gave us positive comments about their care; we were also told they felt safe with the care and treatment the practice provided.

There were systems in place to support the staff working at the practice and keep the patients using the services safe. Root cause analysis of incidents showed the learning points that were identified. These learning points had prompted the practice to make changes to procedures where needed.

There were procedures, policies, staff guidance, checking processes and risk assessments in place to support the staff working at the practice, these helped keep the patients using the service safe.

Safeguarding guidance, with contact details and referral information to the local social services safeguarding team was current and referral details were available and up-to-date.

Risks to patients were assessed before care and treatment was commenced. Documentation used showed that checks were performed and risks were explained to patients before their treatment. This ensured safe patient care.

There was a range of standard operating procedures (SOPs) in use by the dispensary staff for guidance. SOP's are written work processes that explain a procedure from start to finish; these processes were regularly reviewed and up-to-date.

The practice and the branch surgery were visibly clean in all areas on the day of inspection.

The practice manager told us that during the recent coastal flood events the practices business continuity plan had been put on stand-by in case patients needed medical support.

We checked the equipment used at the centre and saw that where required these had been annually calibrated in line with manufacturer's guidelines.

The emergency equipment was regularly checked, in date, and appropriate for emergency use.

Our findings

Safe Patient Care

Policies and procedures were available for reporting accidents and incidents and responding to complaints, these were in line with national and statutory guidance from the Health and Safety Executive. Staff we spoke with were clear about whom to approach if they needed further help advice or support.

The practice had a system for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed.

During the day of inspection we spoke with 17 patients who gave us positive comments about the care they received at the practice. People told us they felt safe when they attended their appointments and consulted with the doctors and nurses. We saw that there were no complaints raised regarding patient safety and the comment cards we had left for members of the public to complete who attended the practice raised no issues regarding safety with patient care.

Learning from Incidents

The practice had a system to record, investigate and learn from adverse incidents. We saw the incidents policy had been recently reviewed, and the actions taken for each The incidents followed a root cause analysis with a brief summary that followed the investigation and learning points identified a change procedure where needed.

The dispensary also had a system to record errors, investigate and learn from incidents. We saw that one minor dispensing error had been recorded in the last 12 months. We saw the actions recorded and the changes that had been made to the dispensing checking procedures. This minor error had been rectified before the medication was given out to the person.

We were shown meeting minutes where incidents had been discussed. These showed the learning points that had been gained or any to change to practice procedure following an incident and investigation were shared with staff in the practice.

Are services safe?

Safeguarding

The practice had appointed one of the GPs as the safeguarding lead. The lead role included promoting staff awareness of safeguarding and communication with other healthcare professionals linked with the practice regarding these issues. Where there were safeguarding concerns with patients registered at the practice, these were identified on the patient computer records system to ensure staff were alerted.

Staff told us if they had any safeguarding concerns, they would refer them to the safeguarding lead at the practice. We were shown the guidance, contact details and referral information to the local social services safeguarding team that were used for safeguarding referrals. The safeguarding information was current and referral details were up-to-date.

The patients we spoke with told us they felt safe using the services at the practice. We saw there was a chaperone facility available to patients attending the practice. There were posters in every treatment and consultation room that communicated the chaperone facility for patients to use. A member of staff told us that a chaperone did not have to be pre-arranged before an appointment and the practice could always accommodate patient's requests.

Monitoring Safety & Responding to Risk

The practice manager told us that they reviewed staff levels so patients' needs were met in a safe way. The registered manager told us the practice rarely needed to employ locum cover, because the doctors at the practice covered their colleague's annual leave and sickness where possible; this meant patient care was consistent.

The registered manager told us that risks to patients were assessed before care and treatment was commenced.

All staff were trained in cardio-pulmonary resuscitation (CPR) and reception staff knew the practices protocol in the event that a patient had chest pain, or was excessively out of breath and what action to take. During the day of inspection we observed this protocol put into action, all staff members involved knew what to do and remained calm. The event resulted in a quick and positive outcome.

Medicines Management

We viewed the dispensary for the practice, which was run from the branch surgery in Alresford. There was a range of standard operating procedures (SOPs) in use by the dispensary staff for their guidance at work. SOPs are written work processes that explain a procedure from start to finish; these processes were regularly reviewed and up-to-date. We checked the SOPs with the staff member at work in the dispensary on the day of inspection, and saw evidence that the dispensary followed their own procedures. For example we saw the practice Dispensing Review of the Use of Medicines (DRUMs) in use when handing out medication to patients. DRUMs are a structured process for dispensing staff to check the patients understanding of their medicines, and their ability to obtain and use them. A reminder for staff to use DRUMs had been attached to the wall at the hatch where patients were given their medication.

We saw there were processes in place to check stock expiry dates, dispensary and fridge temperatures. We were shown the evidence that these checks followed the dispensary's own SOPs.

Information for patients regarding repeat prescriptions was clearly stated in the patient guide to services leaflet and re-enforced with notices in the waiting room and reception areas. Repeat prescriptions were provided on a 28 day cycle in line with the practice policy. Arrangements could be made for alternative cycles if circumstances arose that required a different time period.

Cleanliness & Infection Control

The practice and the branch surgery was visibly clean in all areas on the day of inspection. We saw there were signs informing patients and staff of good hand washing techniques displayed next to hand washing facilities.

We were shown the cleaning schedules for the practice and branch surgery. We were told these were checked by a senior member of staff to ensure they had been completed on a daily basis appropriately. Although we saw the practice environment looked clean, and we were told the cleaning checks were taking place, these checks were not recorded. When we inspected there was no written evidence to prove the checks had been completed.

The practice took immediate action and changed their recording processes to include a signed and dated section for checks to their cleaning processes. We also reviewed the treatment and minor surgery room, infection control risk assessment document; this showed the frequency of checks and the nurse responsible for making the checks to ensure they were not missed in the future.

Are services safe?

Dealing with Emergencies

The practice manager told us that during the recent flood warnings that a risk assessment had been made of the patients living in area's that may need to be evacuated and assessment had been made of their possible medical needs and how the practice should react. A continuity plan had been written to ensure the continuation of the service should the practice become flooded and the risks to the registered population

Equipment

We checked the equipment used to monitor patients with chronic disease at the practice and saw that, where required, this had been annually calibrated in line with the manufacturer's guidelines.

The emergency equipment was regularly checked, in date, and appropriate for emergency use. We saw and were told the equipment checks were taking place but these checks were not always recorded, therefore there was no regular written evidence to prove the checks had been completed.

The practice took immediate action and changed their recording processes to include a signed and dated section for checks to equipment.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

The registered manager told us to promote best practice, that access via the internet on computer desktops was available and used by all the clinical staff at the practice to identify relevant legislation, latest best practice, and evidence based guidelines.

The commitment by the practice to provide good quality of care, and to recall and monitor chronic disease at the practice was seen in the improved quality outcomes figures. This information is published annually about practices regarding clinical quality and is available to access.

Within the area of staffing, the induction process for newly recruited members of staff was effective and appropriate for their roles. Staff told us they had received training within the last 12 months for cardio pulmonary resuscitation training, safe guarding children and vulnerable adults.

There was a clinic held regularly at the surgery by a health trainer. A health trainer is somebody trained to help with behaviour change and to provide motivational coaching in order to help achieve long-term lifestyle goals. The health trainer told us that the clinicians supported their work and referred patients appropriately to them. The health trainer told us that the clinicians supported the work the health trainers provided.

When new people registered at the practice they were invited to attend a new patient consultation where information was gathered on health and lifestyle with the health care assistant. This appointment was used to give health promotion information to patients, and information about the services available in the local community.

Our findings

Promoting Best Practice

During our conversation with the registered manager we were able to ascertain that care and treatment was delivered in line with recognised best practice standards and guidelines. We were told that in order to identify relevant legislation; latest best practice and evidence based guidelines clinical staff had access to the internet on their computers. Policies, procedures and clinical guidelines were available on their computer desktops and Royal College of General Practitioner standards were used by clinicians to provide care and treatment to the patients using their service. National Institute for Health and Care Excellence (NICE) guidance was reviewed for appropriateness and any relevant information was shared with clinical staff.

The practice aimed to deliver high quality care and participated in the quality and outcomes framework (QOF). QOF is a system to reward general practices to provide good quality care to their patients, and to help fund work to further improve the quality of health care delivered.

The practice undertook minor surgery. There were procedures to obtain informed consent for this. We saw the document used to obtain consent that clearly outlined the benefits and side effects that could be experienced from the treatment patients were to undergo.

Management, monitoring and improving outcomes for people

We were able to see from available published information the work done at the practice to monitor chronic disease management through QOF indicators. This information showed the practice's commitment to provide quality care and to recall and monitor patients to ensure care outcomes were improved. The two GPs we spoke with told us about other monitoring done at the practice to improve outcomes for patients. For example, the use of 24 hour blood pressure machines to check continued blood pressure treatment. The practice also include patients' own blood pressure machine readings to patients monitoring to reduce the number of visits that patients with chronic disease need to make to the practice.

Are services effective?

(for example, treatment is effective)

Staffing

The majority of staff at the practice had been employed for several years. We reviewed the induction process for newly recruited members of staff and found them effective and appropriate for their roles.

Staff told us they had received training within the last 12 months for cardio pulmonary resuscitation training, safeguarding children and vulnerable adults.

Colne Medical Practice is an approved teaching practice to train new GPs. GPs that are training are called GP in training, they have a designated GP trainer who supervises their work and provides clinical support. The GP trainer told us they supervised and supported the work of the trainee GPs when working in the practice. They were available for advice if required and held supervision meetings to understand any learning points they needed.

Working with other services

We spoke to a community midwife who was visiting the practice on the day of our inspection. The midwife told us that communications were effective both between the administrative staff, the clinical staff and the midwifery service in the area. The midwife said they were able to access the records system at the practice and could get the information regarding results for patients to support their ante-natal needs. The midwife also told us that the GPs were approachable if there were any issues that needed to be discussed.

The health visitor service told us, when we contacted them prior to the inspection, that the practice provided space to for a drop-in clinic for mothers with their babies and young children. We were also told the health visitor service was invited to the multi-disciplinary team meetings at the practice with the clinical staff members.

The practice also gave space to a health trainer to run weekly clinics; this service uses people that are trained to help with behaviour change and to provide motivational coaching in order to help achieve long-term lifestyle goals. We spoke with the health trainer who held a clinic at the practice regularly; they told us that the GPs and nurses referred patients to them. They also told us that they were always welcomed and accommodated by the practice staff.

Health Promotion & Prevention

When new people registered at the practice they were invited to attend a new patient consultation where information was gathered on health and lifestyle with the health care assistant. This appointment was used to give health promotional information to patients and information about the services available in the local community.

We were told about frailty visits done by the nursing team at the practice for patients who lived at home and were unable to visit the practice. During frailty visits the nurses completed basic health checks, phlebotomy, immunisations and medication reviews.

There was a leaflet rack within the waiting room which this contained leaflets specific to the practice. It also held other leaflets with detailed information about services available in the local community or from the local authority. There were posters displayed about services for vulnerable groups, support groups, and carers.

The practice agreed to take steps to ensure information in the leaflet stand was on full view to patients as it was partly obscured on the day of our inspection.

Are services caring?

Summary of findings

The service was caring.

When we spoke with people visiting the practice during the inspection they were positive about the attitude of the staff and how they were treated.

During the inspection we saw how staff responded to patients and patient's relatives in a manner that showed compassion and understanding.

People we spoke with told us, they felt involved in decisions, that different options were discussed, and they have consented, to their care and treatment when it was applicable.

Our findings

Respect, Dignity, Compassion & Empathy

Our review of the comments cards left by patients showed that they felt the practice was well run, gave care that was an excellent standard and that the doctors and nurses treated patients with dignity and respect.

When we spoke with people visiting the practice during the inspection they were positive about the attitude of the staff and how they were treated. We were given comments that showed patients felt the staff were courteous respectful caring and helpful.

During the inspection we saw how staff responded to patients and patients' relatives in a manner that showed compassion and understanding. We spoke with staff and asked them questions about the way they interacted with patients. We were given a working example by a staff member they told us, if a patient living in a care home came to the practice for an appointment and was anxious they were given somewhere away from the waiting room to wait with their carer. This was to help them reduce their anxiety.

Reception was arranged in a way that meant staff were based where telephone calls could not be overheard, thus private and confidential information could be exchanged if needed. Chaperones were available during consultations of an intimate nature. We found posters in each treatment and consultation room explaining availability. We reviewed the chaperone policy which was in date, and the staff members we spoke with understood and knew the practice procedure to request a chaperone.

We saw the practice held a list of those patients who were recently deceased in an area accessible only to staff members. This enabled staff to respond appropriately if contacted in relation to this person. The practice had information in the leaflet rack with bereavement advice and help.

Involvement in decisions and consent

People told us, they felt involved in decisions, that different options were discussed during consultations, and they had consented, to their care and treatment. We were told by the manager of a local care home for people with a l learning disability that the GPs always helped explain why tests or treatment were needed to the patients in their care in a way they could understand.

Are services caring?

We observed the dispensing staff member checking with patients they understood the dosage instructions on their medication and answered questions about their medications where patients were unclear.

We spoke with the GP about informed consent. We were shown the consent forms and procedures used before treatments and immunisations. These forms explained the risks and benefits of treatment and allowed an informed decision to be made. The practice consent policy explained the practice approach to consent, identifying implied, expressed and obtaining consent acknowledging Gillick competency and the Mental Capacity Act 2005 (MCA). Gillick competency is an established test to determine whether patients under 16 years of age can provide informed consent. MCA is designed to protect patients who can't make decisions for themselves or lack the mental capacity to do so.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs.

When we spoke with people visiting the practice during the inspection they were positive about the attitude of the staff and how they were treated.

During the inspection we saw how staff responded to patients and patient's relatives in a manner that showed compassion and understanding.

People we spoke with told us, they felt involved in decisions, that different options were discussed with them, and they has consented, to their care and treatment when it was applicable.

Our findings

Responding to and meeting people's needs

The practice provided co-ordinated and integrated care for the patients registered with them. They held a range of clinics to provide help and support for patients with long-term conditions such as diabetes and asthma. Other clinics included patients smoking cessation, family planning, minor surgery, child health care and immunisation.

The practice also hosted clinics run by health trainers, health visitors and an antenatal clinic run by the local midwives. A health trainer is somebody trained to help with behaviour change and to provide motivational coaching in order to help achieve long-term lifestyle goals .These clinics were particularly needed for the patients registered at the practice due to its remote location and lack of access the registered population had with other local services.

The local hospital had recently stopped the phlebotomy clinics and moved the service to Colchester. To accommodate the patients that required phlebotomy at the practice they had calculated the number of patients that would be affected by the loss of this service, and increased the nursing staff level and included phlebotomy appointments.

The practice had suitable access and toilet facilities for patients with limited mobility, and a working lift for those patients who needed to access the second floor treatment rooms.

We checked the emergency equipment, emergency drugs and anaphylaxis treatment pack. The equipment and drugs had been regularly checked. We found them to be in date and suitable for emergency use.

Access to the service

The practice operated an open appointment system in the mornings and a booked appointment system in the afternoons. All of the patients we spoke with preferred the open surgery option to access the practice. We were told if the problem was less urgent they could make an appointment and wait to see their doctor. This opinion was also voiced on the comment cards we received.

Are services responsive to people's needs?

(for example, to feedback?)

Out of Hours primary care service provision was carried out by a local provider and information about how to access this service was found in the practice information leaflet and the practice website.

The practice manager told us that during the recent coastal flood events the practices business continuity plan had been put on stand-by in case patients needed medical support.

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.

We saw evidence of regular meetings which discussed the day to day business of the practice such as staff recruitments and appointments, skill mix, safety issues, new initiatives, clinical matters and the actions shown at the end of meeting minutes indicated the person responsible for any work.

The practice had a comprehensive intranet that contained policies, procedures and clinical guidelines including referral criteria and referral forms. All documents had agreed review dates and were seen to be up-to-date. Staff were updated on any changes to these documents at staff meetings and through the practice computer communication system.

The practice encouraged, patient's views and had forms available on their website to express their opinion.

The staff members told us they felt involved with the practice, they were asked to add items to the agenda prior to the staff meetings.

During their appraisals we found staff members talked about their role, objectives, and training or future developments for the practice. These were documented and signed to show that they were agreed.

Risk assessments were carried out, these assessments recognised the hazard, who was at risk, the likelihood of occurrence, the likely severity of risk, the control measures, and the frequency of assessments.

Our findings

Leadership & Culture

The practice's leadership was focused on the importance of quality. This was indicated by the above average quality outcomes framework (QOF) figures against other GP primary care services in the area. QOF is a system to reward general practices to provide good quality care to their patients, and to help fund work to further improve the quality of health care delivered. Staff members we spoke with told us that they felt supported and valued by the management and clinical leaders within the practice.

We saw evidence of regular meetings at all levels which discussed the day to day business of the practice. For example, staff recruitment and appointments, skill mix, safety issues, new initiatives and clinical matters. The actions shown at the end of meeting minutes indicated the person responsible for any work.

We also saw the practice's commitment to using the 'Productive General Practice Programme'. This is a programme of tried and tested tools to support primary care services to improve productivity, improve capability, which should engage the whole team, improve the working life of staff, support patient involvement and develop safer services. It was developed by the NHS institute for innovation. The information was on the staff-room wall and showed the newsletter with the explanation of the module to be undertaken, the information to be gathered, and a request for further staff team volunteers to join in with the work. This was new work for the practice that they were keen to progress to investigate whether improvements could be made.

Within the guide to patients the practice aims for patients were stated, and information regarding the practice being a training practice conveyed.

Governance Arrangements

The practice had a comprehensive intranet that contained policies, procedures and clinical guidelines including referral criteria and referral forms. All documents had agreed review dates and were seen to be up-to-date. Staff were updated on any changes to these documents at staff meetings and through the practice computer communication system.

Are services well-led?

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

The lead nurse at the practice had responsibility for managing the practice nurses and took a lead role in updating and reviewing any clinical issues related to the nursing teams' work.

GPs from the practice attended local clinical groups which met regularly and reviewed clinical issues. This ensured the practice clinical staff stayed up-to-date with local health economy clinical issues.

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

Systems to monitor and improve quality & improvement

The GPs we spoke with told us about the clinical audits they had undertaken. One GP told us about an audit done with a certain medication that had resulted in a change to the procedure used in the practice and prompted clinicians to offer a blood test to patients needing a review. This had led to a decrease in this medicine being used as some patients no longer needed it. Another GP showed us the patient survey they had completed as part of their GP revalidation process; this was part of an audit cycle to collect on-going data to check changes in practice show improved outcome. The survey results were very positive and the GP told us this audit was used for discussion and for learning purposes to monitor performance. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC).

Patient Experience & Involvement

The practice encouraged patient's views and had forms available on the website to express their opinion. The Patient Participation Group (PPG) had recently published a report with the findings from their recent questionnaire. PPGs are groups of patients who have volunteered from practice populations, to form a group for patients to work together to improve services, promote health and improve quality of care for the practice they represent. There were a number of actions that had been taken up by the practice and were in the process of being put into place to improve patients experience whilst at the practice. The first of these actions was to add a trial of evening appointments at the branch surgery which was taken up immediately. The report was available on the practice's web site.

Staff engagement & Involvement

The culture and environment at the practice was open and friendly. The PPG member we spoke with told us that the practice manager and staff supported them with information for their report. The staff members we spoke with told us they worked well together and felt they were a good team. We were told issues were discussed openly in meetings and that the practice manager was approachable if staff had any issues or concerns.

Healthcare professionals that visited the practice told us the staff and clinicians worked well together and were accommodating and flexible with regards to the services they provided for their registered population. One health professional told us it was the best primary care service they worked at.

The staff members told us they felt involved with the practice; they were asked to add items to the agenda prior to the staff meetings they attended. They also told us about the 'Productive General Practice Programme' work the practice had decided to try, and pointed us to the display in the staff room that staff could see showing the modules the practice was intending to try.

Learning & Improvement

Staff told us they had received training within the last 12 months for cardio pulmonary resuscitation training, safe guarding children and vulnerable adults. Some of this training had been delivered internally. The training certificates for staff were kept within the staff records and a single information source of training was recorded on the salary database. When we spoke with the practice manager about this training record, only two or three pieces of information could be recorded against a name and so did not give an up-to-date comprehensive overview of the staff training records for the practice.

We were shown completed appraisals which staff members were given the opportunity to make comment on before the appraisal. We found from staff records that during their

Are services well-led?

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

appraisals staff members talked about their role, objectives, and training or future developments for the practice. These were documented and signed to show that they were agreed.

We were told by staff members that if there was a course of training available that was relevant to their role the practice manager was happy to send them.

Identification & Management of Risk

We were shown the infection control risk assessments carried out on the treatment rooms. These assessments recognised the hazards, who was at risk, the likelihood of occurrence, the likely severity of the risk, the control measures, and the frequency of assessments. The risk assessments showed the staff member responsible, they had been reviewed, and were appropriate for use.

During the inspection someone arrived at the practice with emergency symptoms, we saw that the practice staff followed their procedure quickly and effectively to deal with this event. It was clear that all staff members involved in the incident from reception through to clinical staff understood the process and knew what they needed to do.

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

The practice had systems to identify and visit older patients that lived at home or in a care home to ensure regular access to a GP or a nurse. This helped to ensure this population groups health and wellbeing. Medication, treatment, and care was reviewed this included mental and physical health checks.

Our findings

The practice had systems to identify and visit older patients who lived at home or in a care home to ensure regular access to a GP or a nurse.

The practice made health check visits for those patients who lived in care homes. During these visits clinicians highlighted key health issues to the patients and their carer's as required and advised them on signs that could indicate the need to access medical care. The health needs of anybody new to the care home were assessed on admission by a GP.

Older people with complex needs who were house bound and needed regular assessments due to their frailty were visited by the nurse from the practice in their home. This pro-active healthcare and advice was also given to older patients when they received their annual flu vaccinations. This helped to ensure this population group's health and wellbeing.

All people over the age of 75 registered at the practice had a named accountable GP in line with recent GP contract changes for 2014 to 2015.

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 to monitor those patients with long term conditions and offer them follow-up reviews to maintain their health optimum.

The practice had arrangements to care for patients with on-going health problems and to support their carer's. There were links with community nurses and palliative care nurses to ensure robust care.

The practice had clinics to manage patients with diabetes, and asthma.

Our findings

There were systems in place to monitor those patients with long term conditions and offer them follow-up reviews to maintain their health optimum.

There were systems in place to monitor those patients with long term conditions and offer them follow-up reviews to maintain their health optimum. They held clinics for; diabetics that offered advice and general health check-ups, asthmatics to help and support patients with their asthma care, smoking cessation to offer advice and help with giving up smoking, family planning including coil fitting removal and advice, minor surgery, child health and immunisation.

The practice also hosted clinics run by local health trainers, health visitors and an antenatal clinic run by the local midwives. A health trainer is somebody trained to help with behaviour change and to provide motivational coaching in order to help achieve long-term lifestyle goals. These clinics were particularly needed for the patients registered at the practice due to the remote location and lack of access the registered population had with local services.

The practice had suitable access and toilet facilities for patients with limited mobility and a working lift for those patients who needed to access the second floor treatment rooms.

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 good systems in place to offer co-ordinated care for this population group. We saw consent processes and saw how they were applied for this group. We also spoke with the Midwife that provided antenatal care and the health visiting service at the practice.

Our findings

The practice had systems in place to offer co-ordinated care for this population group.

We were shown the consent processes at the practice and saw how they were applied for this group. The benefits and risks for immunisation were explained and was consent obtained.

We spoke with a midwife who held an antenatal clinic at the practice. They told us this population group benefited from antenatal appointments held at their own practice. This negated the need for this group to travel to the hospital for the antenatal service.

We spoke to the health visiting service that also held a clinic for this population group at the practice. They told us the practice staff supported them with their appointments and they could always speak to the GPs if they needed to.

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 appointment system ensured patients of working age and those recently retired could make an appointment to see a GP.

Our findings

The practice appointment system ensured patients of working age and those recently retired could make an appointment to see a GP.

The practice manager told us the practice offered later bookable appointments to working age patients registered at the practice. We were told in this way they were able to accommodate working age patients in this group registered at the practice

When speaking with patients at the practice they told us they did not have a problem booking an appointment if they needed one.

The comment cards that were left were positive with regards to the access to practice. Two patients particularly commented that they preferred the open surgery appointment system option in the mornings.

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

We were told by care homes looking after people in vulnerable circumstances overall they had a good relationship with the practice and gave positive comments with regards the access for patients and their care.

Four care homes gave very positive feedback and two care homes that looked after patients with challenging behaviour told us they always accommodated patients they bought for appointments to the practice separately so that they did not feel anxious and were sensitive to their needs.

Our findings

We found the practice had systems in place to support patients who were vulnerable.

We spoke with care homes supporting patients in vulnerable circumstances and patients with learning disabilities. They told us that overall they had a good relationship with the practice and gave positive comments with regards the access for patients and their care.

Four care homes supporting older people gave very positive feedback. Two care homes that supported patients with challenging behaviour told us if the people they supported needed to attend the practice to see a GP or nurse and may be troublesome or become anxious in the waiting room, they were offered a room to wait with their carer, and were not kept waiting too long.

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 had a system to identify people experiencing a mental health problem and then refer them appropriately. Services were offered with the local NHS mental health team.

Our findings

We saw the practice, identified people experiencing poor mental health and referred them for treatment to the local NHS mental health team.

We contacted a person from this population group at their request on the day of inspection. They wanted to tell us about the support they had received from one specific GP at the practice. They told us that the whole team from receptionists through to clinicians had shown great care and concern when they had been looked after.