Abbey Field 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.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Abbey Field Medical Centre on Wednesday 17 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia).

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed especially in relation to staff welfare.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients reported to us confusion and difficulty making an appointment with a GP. The practice had trialled a number of appointment systems in an attempt to increase the accessibility of the service. They had decided on an appointment system and were working with the Patient Action Group to increase awareness with patients of the new system and the reasons for the changes.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff had confidence in the practice management team and felt supported and encouraged by them. The practice proactively sought feedback from staff and patients, which it listened to and acted on.

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

Importantly the provider should;

- The practice should adhere to their complaints policy and advise patients of appeals process and the details of the Health Service Ombudsman and advocacy services.
- Ensure that staff receive appropriate training in safeguarding children and vulnerable adults, fire safety and infection prevention control.
- Ensure the practice maintains meeting records of clinical performance discussions

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Staff were able to recognise and report safeguarding incidents although, not all staff had been trained. Lessons were learnt from incidents and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients and staff were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely in their clinical audits. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training and any further development needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and were highly regarded by other professionals. However, we found an absence of meeting records detailing clinical performance discussions this was acknowledged by the practice.

Are services caring?

Good

The practice is rated as good for providing caring services. The practice understood the demographics of their patient population and the social and economic challenges this presented to them. They listened to their patient concerns and worked well with their Patient Action Group to enhance their understanding of patient needs and identify complementary services for them. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The

Summary of findings

practice accepted that patients had experienced confusion and difficulties with their appointment systems due to recent changes. However, the practice were working closely with patients increase awareness of the appointment system and to improve the accessibility of the service. Systems were in place to provide on the day accessible care for both emergency and routine consultations. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Staff were highly committed to delivering good care to patients and learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for the practice and their staff. All staff were clear and committed to the vision and understood their responsibilities in relation to this. The practice had evolved rapidly within the last five years, increasing their clinical team in response to an increase in patient numbers and clinical need. Staff told us they had great respect for all the partners, they felt fully supported by the management team and their colleagues and their opinion was invited, listened to and valued. The practice had a number of policies and procedures to govern activity and held weekly governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The Patient Action Group (PAG) was fully engaged, and was acknowledged as an active and invaluable critical friend to the practice. Staff had received role specific inductions, regular performance reviews, training and attended and engaged in staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. All patients over 75years of age had a named GP and were invited to health checks. The practice offered proactive, personalised care to meet the needs of the older people in its population. They met regularly with patients and their families and undertook weekly checks on patients residing in a care home. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of unplanned hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and those who were at risk. The practice conducted baby checks, and babies and children were assured of on the day access to GPs. Immunisation rates were high for all standard childhood immunisations and the practice monitored uptake rates and followed up on non-attendees. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Information and advice on sexual health and contraception was provided during GP and nurse appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students)

The needs of the working age population, including those recently retired had been identified and the practice had adjusted the

services it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered all patients between 40 and 74years of age without existing medical conditions health checks and offered Saturday morning appointments once a month. The practice was also proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people those circumstances may make them vulnerable.

The practice understood the needs of their patient groups and identified vulnerable patients. They were committed to improving their health and welfare. The practice provided specialist care in the assessment and management of patients dependent on opiates. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice worked with specialist accommodation providers to ensure patients with no fixed abode could access medical services. They practice promoted and facilitated meetings with care advisors and a Social Prescription (charity) who identified patient welfare needs and supported them to access services within the community. They worked with care homes for people with a learning disability and carried out annual health checks for people with a learning disability, offering longer appointments.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients experiencing poor mental health are invited to an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia and specialist child and adolescent mental health services. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

Prior to our inspection we also sent CQC 'Tell us about your care' comment cards to the practice for distribution among patients in order to obtain their views about the practice and the service they received. During our inspection we also spoke with five patients to gain their views of the service provided. We also reviewed data available from NHS Choices and the National GP Patient Survey results from 2015.

We reviewed the findings of the National Patient Survey 2015 for which there were 110 responses from the 330 questionnaires distributed to patients, a response rate of 33% of those people contacted. The practice performed in line with or above the national and CCG average with 92% of respondents say the last GP they saw or spoke to was good at giving them enough time and 89% of respondents say the last GP they saw or spoke to was good at listening to them. 82% of respondents also said the last GP they saw or spoke to was good at treating them with care and concern. Although this was slightly below the Clinical Commissioning Group average of 84% and the national average of 85%. The practice performed below the Clinical Commissioning Group average and national averages for; respondents with a preferred GP usually getting to see or speak to that GP, finding the receptionists at the surgery helpful and for being able to get an appointment to see or speak to someone the last time they tried.

We reviewed patient comments on the NHS choices website. We found eight reviews had been made within the last 12 months. Negative patient reviews related to poor patient care by both clinical and administrative staff, confusion and a lack of accessibility over the appointment system. All comments had been acknowledged by the practice and appropriately responded to.

We provided the practice with comment cards ahead of our inspection and invited patients to complete them so we may capture their experiences of the service. 11 of the comments were supportive of the practice. We received 21 completed 'Tell us about your care' comment cards.

Patients told us they had confidence in the clinical and administrative staff who they described as friendly, polite and helpful to them. However, 10 of the comment cards made reference to difficulties understanding and obtaining appointments including access to urgent on the day appointments. This was accepted by the practice and they had changed their appointments system four times within the last 12 months in an effort to enhance accessibility of the service and meet growing patient demand. The practice told us they intended to maintain the current appointment system and believed that this would improve patient access to the service and enhance continuity of care. Patient comments were shared with the practice and they told us they would discuss them at their next meeting with their Patient Action Group in June 2015. The practice Patient Action Group is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

We spoke with the manager of one care home where a number of the practice's patients resided. The home manager told us that they were happy with the service they received. The GP attended at their request, was polite and respectful to the patients and explained to the patient, patient's family and the carer what they were intending to do prior to examining the patient. They told us how the GP explained the outcome of their assessment and why they were proposing a course of treatment. They told us the practice involved friends, family, carers and relevant authority where appropriate with assessments.

We spoke to five patients on the day of our inspection they told us that the staff were polite and helpful.

They told us the reception staff were good at trying to facilitate a patient appointment but the regular changes to the appointment system had caused a lot of confusion and many patients no longer knew whether the practice offered a morning walk-in service or they were required to book an appointment on the day. However, patients told us where there had an urgent clinical need they were seen by a GP that day.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- The practice should adhere to their complaints policy and advise patients of appeals process and the details of the Health Service Ombudsman and advocacy services.
- Ensure that staff receive appropriate training in safeguarding children and vulnerable adults, fire safety and infection prevention control.
- Ensure the practice maintains meeting records of clinical performance discussions

Abbey Field Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a CQC GP and CQC practice manager.

Background to Abbey Field Medical Centre

Abbey Field Medical Centre is situated in a modern purpose built medical centre. The practice moved to the premises two years ago from their previous site called Mersea Road Surgery. The practice has a patient population of 10,950. The practice is managed by three GP partners who hold financial and managerial responsibility for the practice. They employ three salaried GP's (one of whom was on maternity leave at the time of the inspection), three practice nurses one of which is a prescriber and two healthcare assistants supported by a reception and administrative team.

The practice offers appointments with both male and female GP's with an equal complement of both. They are a training practice aligned to Barts and The London - School of Medicine and Dentistry. The practice had four registrars working at the time of the inspection. Registrars are qualified doctors training to be GPs. The practice also actively participates in medical research studies.

The practice holds a primary medical services contract with NHS England to provide medical care to patients.

The practice is open between 8am and 6:30pm on Mondays, and 7am and 6:30pm Tuesdays to Fridays. Early morning clinics from 7am to 8am on Tuesdays, Wednesdays, Thursdays and Fridays are for pre booked appointments. Appointments may be made in person, on the phone or via their practice website online. Appointments are available for health checks with the healthcare assistance on a Saturday. Home visits are undertaken on request and emergency appointments are facilitated on the day.

The practice demographics are similar to the practice averages across England with slightly less patients under 18 years of age and lower representation amongst the aging population of 65years, and over. Their patient income deprivation levels for children were slightly above the practice average for England and they had a higher number of disability claimants per 1000 than the practice average. The life expectancy of both men and women were in line with the national average life expectancy of 79 years for men and 83 years for women.

The practice maintains a comprehensive website detailing practice opening and consultation times, information relating to their Patient Action Group meetings and decisions taken and providing a range of advice on services including what to do in an emergency. The PPG is a group of patients registered with the practice who work with the practice to improve services and the quality of care.

The practice has opted out of providing out-of-hours services to their own patients. Patients are advised to call 111 when they require medical assistance but it's not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones. Patients are advised that patients can be seen at all times at the A&E Department at Colchester General Hospital and minor ailments can be seen between 7am and 10pm at the Walk-In Centre on Turner Road in Colchester.

Detailed findings

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 June 2015. During our visit we spoke with a range of staff, practice manager, reception staff, clinical team including the GPs and practice nurses and spoke with patients who used the service. We talked with carers and/or family members and reviewed documents. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

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

National patient safety alerts were disseminated by the practice manager who maintained an accessible record on the practice's intranet system for staff to review. There was an appointed lead GP to oversee all such information was being appropriately reviewed and actioned. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed amongst staff and were aware of any that were relevant to the practice and where they needed to take action.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed the practice records of 11 significant events that had occurred during the last 18 months. We tracked incidents and saw records were completed in a comprehensive and timely manner.

Staff told us significant events were discussed where appropriate at the practice weekly partners meeting which were held each Tuesday and risks of recurrence were mitigated. There was evidence that the practice had learnt from these incidents and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. For example, The practice had reported failure of their staff to close a vaccination fridge, resulting in the loss of a large quantity of vaccinations. This resulted not only in a financial loss of stock but also delayed patients being able to access vaccinations as planned. The practice undertook an internal investigation whereby they spoke to staff and reviewed their processes and systems. Their findings resulted in awareness training for staff and changes to their operating practices to mitigate the future risk of stock being lost as a result a similar incident. This showed the practice had reported, investigated and managed risks consistently over time.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all GP's had received relevant role specific training on safeguarding to the required level for children and young people. However, three of the GPs had not undertaken training in safeguarding adults. We also found that three staff out of nine had not undertaken safeguarding children training to the required level 2 or safeguarding adults; all of which were non-clinical staff. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil the role. They coordinated all responses to information requests from relevant agencies involved in safeguarding children and vulnerable adults. The lead GP for safeguarding reported receiving weekly requests for such information. Whilst they did not attend designated child protection meetings they prepared detailed reports for consideration. All staff we spoke with were aware who the lead GP was and who to speak with in the practice if they had a safeguarding concern.

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

There was a chaperone policy, which was visible on the waiting room noticeboard, in consulting rooms and on the practice web site. (A chaperone is a person who acts as a

safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff and health care assistants had been trained to be a chaperone. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Records showed all medicines were in date and accounted for.

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

We found a safe and effective system was in place in relation to the issuing of repeat prescriptions. For example, prescriptions produced by the prescription clerk at the request of the patient or pharmacy were initialled by the clerk and issued to the relevant GP to sign. These were then returned to the clerk on being endorsed by the GP who then rechecked the prescription to ensure they were correct in both the name and details of the patient and the medicines being requested. The prescription clerks were also authorised to message the pharmacy or patient to alert them to reviews and checks as required to help ensure the safe and appropriate management of their therapy. The clerk showed us how they used the practice repeat prescribing protocols to ensure consistent and timely information was relayed.

We found prescription were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However, we found that two significant incidents had been recorded in relation to prescribing. We found that one of the incidents was an administrative error and an apology was sent to the patient. The other was a similar error which led to practice wide training in diabetes medication to improve understanding amongst staff of the differences of medicines.

The practice told us of their regular meetings with the Clinical Commissioning Group prescribing advisor. The practice was within their prescribing budget and continued to review their patterns of prescribing to reduce patient dependency on high risk medicines such as opiates. The practice also had clear systems in place to monitor the prescribing of controlled drugs. Requests for controlled medicines were reviewed and reissued by GPs independently of the prescribing clerk.

The nurses used Patient Group Directions (PGDs) written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for the treatment. We saw sets of PGDs that had been updated. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable

gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff had received their Hepatitis B vaccination to mitigate the risks of them acquiring a blood borne infection.

The practice had a lead GP and practice nurse responsible for infection control. The practice nurse had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We found that not all staff had undertaken specific infection prevention control training but learning was cascaded by senior staff and staff development needs were identified within staff training and development plans. We saw evidence that the lead had carried out audits for the practice and specific high risk areas such as the minor surgery suite. Any improvements identified for action were completed on time such as the introduction of more specific clinical cleaning schedules to demonstrate how risks of infection were mitigated between clinical interventions.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients and a formal assessment was next to be conducted in August 2015.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, defibrillators, blood pressure monitoring devices, ultrasounds and the vaccination fridge thermometer were all tested in May 2014 and scheduled to next be tested in May 2016.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at three recruitment files for staff recruited within the last 12 months; two practice nurses and a receptionist. We found that all elements of all appropriate recruitment checks had been undertaken for staff prior to employment such as photos, references, professional registration, skills and qualification. All staff had also undertaken appropriate checks through the Disclosure and Barring Service. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice conducted checks to ensure their clinicians were registered with their appropriate professional body. All staff were also aware of their obligation of notifying the practice should restrictions or issues be raised with their professional body.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. We found risks were appropriately assessed, rated, monitored and where appropriate control measures introduced to mitigate the occurrence.

The practice had identified risks and openly discussed and reviewed their management of them. Risks relating to the health safety and wellbeing of staff were well documented and mitigated through regular assessments, review and amendment of management strategies to best meet the

Good

Are services safe?

business and individual's needs. Risks associated with service and staffing changes both planned and unplanned were discussed by the partners. For example, staff raising concerns regarding the sustainability of workload. We reviewed meeting minutes and spoke with staff who confirmed the practice were open and receptive to challenge. They acknowledged the challenging working environment due to high patient demand and were committed to supporting staff in meeting it.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Information was shared with out of hour's provider to ensure continuity of care in the event the practice was closed. The practice also monitored repeat prescribing for patients receiving high risk medication for mental ill-health and patients who were dependent on medicine.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electric shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillators were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan, dated November 2014, was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document did not contain contact details for staff to refer to such as who to contact in the event of the heating system failing. Although these were documented on the practice shared computer drive and accessible to all staff. The plan was last reviewed in June 2015.

The practice had carried out a fire risk assessment and was last visited in March 2015 by Essex County Fire and Rescue Service who advised them that the practice had achieved a satisfactory standard of fire safety. All staff were required to undertake fire safety training every two years. 11 out of 19 staff had not received training this was being actioned by the practice as a priority. A certificate of maintenance was in place for fire equipment.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was reviewed by clinicians and discussed in case discussions and we saw it was assessed within clinical audits. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The practice maintained registers of patients with specific health needs to enable them to more effectively monitor their care and ensure they were accessing appropriate services. For example, patients with diabetes were having regular health checks and were being referred to other services when required.

The GP partners had specialist clinical lead areas such as diabetes, child health, surgery and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. We found the practice was aware of suboptimum performance in routine patient checks and had amended their appointment scheduling to try and encourage attendance by patients at their reviews.

The practice had identified patients who frequently used emergency services or attended hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met, to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital the practice reviewed the patients' needs to ensure they continued to be met.

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

Management, monitoring and improving outcomes for people

We found the practice was proactive in identifying potential risks and improving outcomes for their patients. The practice surveyed all parents of three and a half year olds to screen for potential vulnerability and risk of neglect or abuse. They worked with partner agencies such as health visitors to identify evolving risks in order to respond in a timelier and appropriate manner to mitigate risks early.

The practice data suggested the practice performed lower than the national average in relation to diabetic screening including monitoring blood pressure and the presence of protein in patient's urine. These checks help to identify conditions associated with diabetes including kidney and heart disease. We spoke with the practice that had introduced nurse led diabetes care and had a lead GP who jointly oversaw patient care to ensure patients received their annual checks and details of their educational programmes for patients. All clinicians involved in providing specialist care had received specific training in diabetic care.

Information about patient care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

We found individual GPs led on identifying clinical areas for review which fed into the practice's clinical governance system. Clinicians were required to present their findings for clinical audits to the clinical team to increase awareness amongst them and improve patient care. The practice showed us four clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice conducted a clinical audit into urinary tract infections (a common bacterial infection) in children to assess the practice's adherence to NICE guidelines in the care of patients. The audit identified a

Good

Are services effective?

(for example, treatment is effective)

lack of compliance with current recommendations and a need for stricter adherence to the guidelines and protocols. The findings were presented to the clinical team and a re-audit conducted within six months following the introduction of care pathways for children with urinary tract infections to assess if patient received more timely and appropriate clinical interventions.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of emergency contraception. The clinical audit considered the form of emergency contraception provided, advice on long-acting reversible contraception and sexually transmitted infection screening in response to the updated guidelines issued by the Faculty of Sexual and Reproductive Healthcare. The audit was considered important given high UK statistics for unwanted pregnancies and the local area demographics. The audit identified errors in patient record coding and a disparity in the services received by patients attending the practice and those accessing the walk in centre provided by an external service. Patients who attended the practice received a more comprehensive service providing advice and screening referrals. Recommendations included training for all clinical staff and the sharing the audit findings to educate staff and potentially reduce the number of unwanted pregnancies due to insufficient awareness by patients of the contraception options available to them.

We reviewed a completed two stage audit cycle. The audit considered the practices adherence to the diagnosis and assessment of risk for patients with hypertension in response to NICE guidance. The initial audit findings conducted between September 2014 and December 2014 found insufficient clinical investigations being conducted despite the presence of reminders on the clinical record system. The results were shared amongst the clinical team to enhance the clinicians understanding and awareness of the risks to patients. The second audit cycle completed for new diagnosis of hypertension from February to the end of May 2015 showed an improvement in the clinical investigations conducted. However, it still identified areas for development, as not all patients had been afforded the same standard of clinical care. A further clinical cycle was proposed within 12 months.

The practice met with the local CCG medicine management team to review reports on their prescribing performance. Where the medicine management team had recommended changes to a patient's medicine the practice assessed the appropriateness of the recommendations for the individual. Where changes were proposed the GP spoke with the patient and explained the changes and implications for their care.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures the results are published annually.

The practice was an outlier for the percentage of patients aged over 75 years with a fragility fracture who were treated with a bone sparing agent. This suggested that their prescribing rates of bone sparing agent (preserving medicines) were lower than expected for their patients' clinical needs. We reviewed their systems and processes where the practice was notified by a discharge letter of patients' clinical needs. All correspondence was reviewed by the patient's lead GP and then the data coded onto the patient record system. We reviewed four clinical records; three were found to have been appropriately responded to and recorded. However, one of the patients was not receiving all appropriate medicine to best manage their care. The practice assured us they would revisit the system for managing all patient care.

The team was making use of clinical supervision meetings to assess the performance of clinical staff including their educational needs. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly

Good

Are services effective?

(for example, treatment is effective)

check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We found that the practice had acted appropriately in response to court rulings requiring change of medicines after receiving an alert. The GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal and multidisciplinary meetings to discuss and coordinate care and support for patients and their families. However, we found there was limited attendance by some of the invited partners but all were sent the minutes of the meeting for their information and actioning. The district nursing team were regular attendees and the practice had tried to facilitate the needs of parties to maximise attendance.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. The practice operated a flag on the patient system so that they were aware of their individual needs. Structured annual reviews were also undertaken for people with long term conditions.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG) in respect of their prescribing patterns. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with GP partners leading in specialisms and areas of interest such as surgery, long term conditions (diabetes). The nursing team had a broad skill base with staff able to undertake multiple roles in the absence of their colleagues such as phlebotomy (taking of blood), administering of vaccinations and preliminary diabetic health checks.

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

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, all partners were GP trainers and a salary GP was enrolled and undergoing the training.

The practice told us of how they managed poor performance and had evidenced and made recommendations that a staff member was not fit to practice for the protection of patients. This had been appropriately presented and their finding agreed with.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues identified from these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt but regular letters may not be reviewed for up to five days if the GP has a two week holiday/ absence. The GP who saw these documents and results was responsible for the action required.

The practice held clinical team meetings weekly to discuss patients with complex needs. These meetings were attended by the clinical team and decisions about care planning were documented in a shared care record. Staff felt this system worked well. However, we found no record was maintained of the clinical meetings to demonstrate transparency and accountability in decision making.

Good

Are services effective?

(for example, treatment is effective)

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the out-of-hours services.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. The practice manager had undertaken Mental Capacity Act training and was cascading it to non-clinical staff to inform their work and the booking of appointments for children. We found young people under 16 years of age were unable to book appointments on line but were able to in person or on the telephone.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice was constantly striving to educate their patients into understanding and accepting responsibility for their health whilst supporting them to make informed choices. The practice also offered NHS Health Checks to all its patients aged over 75 years. Additional appointments were provided where required to ensure patient needs are accommodated. They had introduced new services to assist patients in managing and addressing their individual health needs such as through smoking cessation interventions.

Data we viewed for 2014/15 showed that the practice performed at or above the local and national averages for the uptake of standard childhood immunisations, seasonal flu vaccinations, cervical screening (smear tests) and annual health checks for patients with one or more long-term health condition such as diabetes and respiratory diseases. At the time of our visit we saw that the practice was monitoring its performance for 2015/16 and were proactively targeting patients who had failed to attend appointments for healthcare screening, immunisations and annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey 2015 and Care Quality Commission comment cards completed by patients.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the National GP Patient Survey 2015 showed that patient experiences were similar or slightly below the Clinical Commissioning Group (CCG) or national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 89% of respondents said the GP was good at listening to them, which was above the CCG average of 87% and in line with the national average of 89%.
- 92% of respondents said the GP gave them enough time, which was above the CCG average of 86% and the national average of 87%.
- 90% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 95%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff overall were efficient, helpful and caring. They said staff treated them with dignity and respect. Ten comments were less positive; the common themes related to the changes in the appointment system that had caused confusion amongst patients. This was reflected in our discussions with representatives from the Patient Action Group and in our conversations with patients on the day of our inspection. This was known and accepted by the practice who committed to a period of stability for the current appointment system to become embedded. The practice Patient Action Group is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to observe patient confidentiality policy when discussing patients' treatments so that confidential information was kept private. There were examples to help staff understand what this meant for patients. The practice switchboard was located away from the reception desk and was shielded by screens which helped keep patient information private. There were also notices advising patients to stand back and wait away from the reception area and this was observed by patients.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

The practice had a good working relationship with support services to ensure people whose circumstances may make them vulnerable had to access the practice without fear of stigma or prejudice. Staff were committed to ensure patients were treated sensitively and individual needs met. We saw patients collected from the waiting area by clinical staff who were polite, engaging and assisted those with visual impairments or mobility issues including parents carrying young children.

Care planning and involvement in decisions about care and treatment

The National GP Patient Survey 2015 information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 78% said the last GP they saw was good at explaining tests and treatments although this was slightly lower than compared to the CCG average of 84% and national average of 86%.
- 76% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 80% and national average of 81%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt

Good

Are services caring?

involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Many of the patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The National GP Patient Survey 2015 information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 82% said the last GP they spoke to was good at treating them with care and concern although this was a little lower than the CCG average of 84% and national average of 85%.
- 84% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice sign-posted patients to carer advisors who were available for patients and their carers to speak with to access services.

All staff were notified of the death of a patient via electronic communication. This triggered the cancellation of correspondence and prescriptions. The GP may refer a patient's family for bereavement counselling at the hospice irrespective of their attendance or use of facility. Relatives and friends advised us that they may self-refer to support organisations such as counselling services

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice has and continues to experience challenges in ensuring it provided a responsive service and offers sufficient appointment availability to their patients. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. Appointment availability was a strong theme within the complaints received by the practice during 2014-2015 and also amongst comments recorded by patients in response to the Friends and Family Test for January to May 2015.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from their patients and in response to discussions and priorities identified with their Patient Action Group. The practice Patient Action Group is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, the practice initially introduced a walk in clinic on Monday mornings in June 2014. This was well received by patients who were guaranteed to see a GP on attending and therefore the service was extended to three mornings a week; Monday, Wednesday and Friday. The extension of these services was actively promoted by staff in person, via the practice website and through the distribution of information leaflets. The practice trialled the system for three months and identified the advantages and potential disadvantages and additional considerations and developed an action plan with staff appointed lead areas of responsibility and accountability. Reception staff had specific guidelines for the management of the walk in appointments. However, after auditing the walk in system they found patients were waiting too long and therefore not being responsive to their needs. The GPs also reported the system resulted in them continually seeing patients without sufficient welfare breaks or opportunities to discuss and review the outcome of consultations with patients. The practice ethos of not turning patients away and to see all patients who presented meant that clinical times were being extended and impacting on their ability to fulfil other duties such as home visits. However, they accepted that despite communicating changes to patients via text, messages on their prescriptions and information displayed within the waiting area some patients had found it difficult to keep track of the changes in the system.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The partner GP was a member of the CCG and with the practice manager attended bi-monthly evening meetings to discuss the health needs of the local community. They were engaged with the local care rapid assessments service to support patients and avoid unnecessary, inappropriate and unnecessary admissions. Under Care Closer to Home, it is proposed that GPs will be able to refer people to a single assessment service, where a doctor, nurse or other clinician will work with the patient to plan their care. A clinician will then make sure that the care plan is carried out and will be on hand to help the patient with any queries.

The practice engaged with the Patient Action Group (PAG) and listened to their feedback, specifically their request for INR testing. Patients taking warfarin need to be tested to see how well the medication is working using the international normalisation ratio (INR). The practice and PAG together raised funds which were divided between for the local hospice and the INR testing machine and specialist software therefore enhancing services provided to their patient group. The practice engaged with the patient group and spoke and educated and explained the benefits of the electronic prescribing service prior to introducing it.

Patients were concerned about the travel distance between their previous practice site and the new premises. It was acknowledged by the practice as a genuine and significant potential barrier to patients accessing care. The PAG worked with the Colchester Community Volunteer Service (CCVS) and the patients and they established a hopper bus for patients to attend the practice. The service was free, regular and could be requested by any patient to ensure they could access the practice services.

The areas of deprivation were actively addressed by the practice. The practice had engaged with Care Advisors where they could book appointments with the healthcare professional and tailor a package of care for that patient. The practice enabled the advisors access to rooms within the practice for the patient's convenience and provided them with an opportunity to speak confidentially with patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, the work closely with Beacon House which was the centre for homeless people in Colchester. They had established a system whereby anybody who was homeless could access their services by registering as temporary residents. Such appointments were made at a convenient time for the patient. They recognised that a number of their patients were opiate dependent and ensured that clinicians had received additional specialist training in meeting and managing their specific patient needs. This had been well received by patients and the practice believed it provided them with high quality care to meet their demographic need.

The practice engaged with Social Prescription, a specialist service designed to support lonely, and vulnerable patients with learning disability. This service helped patients to join friendship groups to help them interact socially and their facilitated meetings at the practice and within the wider community.

All patients with a learning disability were provided with longer appointment times, of 30 minutes. These patients were identified with flags on their patient record to alert clinicians to their potential needs. The reception team were permitted to make extended appointments of 20 minute where they believed it may be beneficial such as the discussion of multiple concerns or related concerns.

The practice had sought to actively engage with underrepresented patient group through inviting organisations such as the Red Cross and Colchester Community Volunteer Service to display information/ have a stand during the walk in clinics to assist them to capture patient views. We found the practice had a system in place for flagging vulnerability in individual patient records.

The practice had and used the induction loop service for patients with hearing impairment and The Big Word for translating services. We spoke to staff and they knew how to access the service and were confident in doing so.

The premises and services had been designed to meet the needs of their patient groups with all rooms on the ground floor, wide corridors, sufficient accessible parking, step free access, automatic doors, accessible toilet facilities with an alert alarm and baby changing facilities. The practice had a large waiting area, which was clean and airy; there was a good selection of notices and a radio playing. The minutes from the PAG meeting were also displayed for patients to read. The practice also benefitted from neighbouring parking facilities and designated parking bays for disabled people.

There was a good clinical mix of staff with three male and three female GPs. Patients could choose to see a male or female doctor.

The practice recognised that some of their patients may present differently and be considered challenging at times. Therefore the practice had engaged with the Medical Defence Union (A defence advisory body to assist with mitigating risks from litigation) to provide education and awareness training to their staff.

The practice provided equality and diversity training through accredited online training. Whilst this was identified as mandatory by the provider not all staff had undertaken the training. However, we saw that staff treated people with dignity and respect.

Access to the service

The practice was open between 8am and 6:30pm Mondays and 7am and 6:30pm Tuesday to Friday. Early morning clinics from 7am to 8am on Tuesdays, Wednesdays, Thursdays and Fridays were for booked appointments only. The practice provided six hours of GP time per week in their extended hour's service. The practice website had not been updated to reflect the practice's current appointment system. However, it did advise patients how they may arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Appointments could be made in person, on the phone or via their practice website online. The practice also offered Saturday appointments with the healthcare assistance once a month for health checks. This is currently offered as a trial and subject to review. We found where appropriate patients were issued follow up appointment slips of paper

Good

Are services responsive to people's needs?

(for example, to feedback?)

to hand to reception. This was to enable them to book in advance follow up appointments and annual reviews to meet their individual needs, providing continuity of care with the same clinical team.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits and reviews were made on request and where a clinical need existed.

The National GP Patient Survey information we reviewed for 2015 showed patients reported difficulties with accessing appointments despite 75% of the respondents being satisfied with the practice's opening hours compared to the CCG average of 74%, and 93% respondents describing the last appointment they got was convenient compared to the CCG average 94%. The practice acknowledged this as an area for improvement with 74% of respondents reporting they were able to get an appointment to see or speak to someone the last time they tried as opposed to the CCG average of 86%. 62% of respondents also described their experience of making an appointment as good, this was lower than the CCG and national averages which were 72% and 73% respectively.

Patients we spoke with were confused by the changing appointment system that had occurred four times within the last 12 months. Patients confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice worked with partnership and specialist services such as the tissue viability service and the Children and Adolescent Mental Health Service to develop and manage a package of care.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system and this was displayed in the waiting area and staff were confident in speaking with patients regarding concerns. Patients we spoke with were not aware of the process to follow if they wished to make a complaint but had confidence in staff that they would listen and act appropriately to resolve their concern. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 17 verbal and written complaints received since April 2015 and found they had recorded all concerns which were dealt with well in a timely way, and with openness and transparency. We found that the practice were acknowledging complaints but were not sending a written response as detailed in their practice policy or sending a patient the complaints leaflet advising them of the appeals process and the details of the Health Service Ombudsman and advocacy services.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and themes such as appointment availability had been identified. The practice continually thrived to improve the service delivered to patients through learning lessons from individual complaints had been acted on and improvements made to the quality of care as a result. These were discussed through both partner and practice meetings and with administrative staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and they had aspirations to join with a neighbouring practice and enhance the services provided to their patients. The practice encouraged and accommodated complementary services such as Care Advisors and Colchester Community Volunteer Service who used their premises to assist vulnerable persons within the community. The practice also rented out their premises to other health services such as the midwife service. Thereby, providing an accessible service to patients and promoting understanding and communication between health professionals.

We spoke with the Patient Action Group who spoke highly of the commitment energy and professionalism of the GP partners and the practice staff. (A PAG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). They told us staff believed passionately in the right of patients to have access to medical services and wanted to provide them with the best possible service.

The practice held regular meetings with staff, who valued their involvement and the opportunity to have their opinion considered and responded to. Although all staff told us, they would happily speak with any of the GP partners outside the meetings should they wish to discuss anything and felt confident they would be supported and encouraged to do so.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at policies and procedures and found they were updated but would benefit from a critical review to ensure they reflected changes in legislation and best practice.

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

The GP and practice manager took an active role in seeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. Staff told us QOF data was regularly discussed at weekly partner meetings and actions were assigned to maintain or improve outcomes. These were not always documented and revised to ensure they were addressed and the issues did not reoccur. The practice acknowledged this as an area for development.

The practice identified, recorded and managed risks such as staffing and clinical. The practice held weekly partner meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed and managed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, including individualised induction programmes developed for staff specific to their roles and responsibilities which were in place to support staff. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. Staff told us they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how the practice ran and how best to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

Practice team meetings were held every two months and included clinical and non-clinical staff. Very brief minutes were taken that reflect action points identified, assigned to people highlighting salient points.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the Patient Action Group, surveys and complaints received. It had an active Patient Action Group (PAG) which included representatives from various population groups, including older people and those with long term conditions. The PAG had carried out surveys to understand patient's experiences of the appointment system and to assist them to best represent their needs to the practice. The PAG discussed the findings of their surveys, their own experiences and the experiences of other patients shared with them. We spoke with two members of the PAG and they were very positive about the role they played and told us they felt fully engaged and valued by with the practice. (A PAG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the National GP Patient Survey to see if there were any areas that needed addressing. This highlighted concerns relating to the accessibility of appointments.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions held formally and informally. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us how they valued the pleasant and supportive working environment where all staff had an equal voice and they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. These were aligned to both individual practitioners' interests and the practice's business needs. Staff told us that the practice was very supportive of training and that they had guest speakers and trainers attend partner meetings.

We found a culture of openness and challenge amongst the clinical team, with a commitment to deliver appropriate and good quality care to patients. This, they thrived to achieve through sharing experiences and listening and valuing the professional opinion of their peers. All nursing staff received clinical supervision either one on one and as a team. Although direct clinical observation was not documented on their personnel files or within the patient record. The practice acknowledged the need to formalise current clinical supervision arrangements for transparency and professional governance.

The practice was a GP training practice aligned to Barts and The London - School of Medicine and Dentistry. They had four registrars working with the practice at the time of our inspection. Unfortunately, none were present to provide feedback on the day. However, the practice was exceptionally proud of their role as a training practice and believed it encouraged an open environment whereby the clinicians were receptive to challenge. They spoke of the challenges they faced as a training practice. The GP partners praised the professionalism of staff to support trainees to achieve and courage to address underperformance.

The practice had completed reviews of significant events and other incidents and learning shared with staff and formally addressed at meetings.