Tollgate Health 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 Tollgate Health Centre on 22 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for 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 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, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Importantly the provider should:

- Ensure dissemination of learning from investigations is shared with all practice staff
- Provide management support and appraisals for the practice manager.
- Ensure blank prescription pads are logged and audited so that risks of misuse are mitigated.

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 report incidents and near misses. The practice does not always use every opportunity to learn from internal and external incidents to help them improve. Information about safety was highly valued and was used to promote learning and improvement. Risks to patients and within the practice were assessed and well managed. There were enough staff to keep people safe. There were safe and well organised arrangements for the management of infection prevention and control.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. With the exception of the practice manager Staff undertook had annual appraisals which identified learning needs from which action plans were documented. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us their GP gave them the time and attention they needed and listened to them. Most patients we received information from were complimentary about the helpfulness of reception staff who recognised and accommodated their individual needs when they visited the practice.

Staff of local care homes described the service provided by the practice as supportive and professional and the approach of the GPs as compassionate. They were very satisfied with the care and treatment patients received and highlighted the caring approach of the GPs to patients' families.

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

Summary of findings

NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had open and supportive leadership and a clear vision for the future of the practice including expansion to meet increased demands. The practice promoted high standards and the team took pride in delivering a high quality service to its patients. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly to review the delivery of care and the management of the practice. The practice had systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and responded to suggestions made. The practice had an active patient participation group (PPG). A PPG is made up of a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. 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 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 patients 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

This practice is rated as good for the care of families, children and young people. The practice provided childhood immunisations and appointments for these could be booked throughout the week to provide flexibility for working families. The practice provided a family planning service and a range of options for contraception. The GPs and nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances. They had systems to identify and follow up children living in disadvantaged circumstances and worked in partnership with other professionals such as health visitors to monitor their well-being. Immunisation rates were in line with the local clinical commissioning group average. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was 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

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a learning disability register and all patients with learning disabilities were invited to attend for an annual health check. Longer appointments were available for this and the practice used information in suitable formats to help them explain information to patients. The practice provided care and treatment to homeless people. Staff recognised that these patients frequently had multiple health and social difficulties and encouraged them to come back to the practice for on-going care.

Staff worked with other professionals to help ensure people living in difficult circumstances had opportunities to receive the care, support and treatment they needed. The staff team were aware of their responsibilities regarding information sharing and dealing with safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice held a register of people experiencing poor mental health and invited them to attend for an annual health check and other opportunistic checks were carried out at this time. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. 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

Data available from the NHS England GP patient survey results published in January 2015 showed that the patients had reported positive views about the practice.

- 93% said the GP was good at listening to them compared to the CCG average of 87% and national average of 89%.
- 88% said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 98% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 92% and national average of 92%.
- 96% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 92% and national average of 91%.
- 87% said the last GP they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 84% and national average of 85%
- 83% 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%.
- 88% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

We also gathered patients' views by looking at 12 Care Quality Commission (CQC) comment cards completed by patients. On the day of the inspection we spoke with nine patients, two of whom were members of the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

Information from patients we spoke with and from the comment cards gave a positive picture of their experiences. Several patients described the service they received as being excellent and described the staff team as professional, caring and pleasant. In some of the comment cards patients highlighted that their GP listened to them and gave them enough time during appointments. One commented that they always left the practice feeling the GP had listened to them and another remarked on the patience of GPs in listening to them. Other patients confirmed that the GPs and nurses explained the tests, treatment or medicines they needed clearly so they understood what was happening and why.

All patients we received information from were complimentary about the helpfulness of reception staff who recognised and accommodated their individual needs when they visited the practice.

We spoke with senior staff from six local care homes where some of the practice's patients lived. They described the service provided by the practice as professional and the approach of the GPs as compassionate. They were very satisfied with the care and treatment patients received and highlighted the caring approach the GPs also took with patients' families.

Areas for improvement

Action the service SHOULD take to improve

- Ensure blank prescription pads are logged and audited so that risks of misuse are minimised.

Tollgate Health 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 GP and a practice manager.

Background to Tollgate Health Centre

Tollgate Health Centre is located on the outskirts of Colchester. The practice provides services for approximately 6,600 patients living in Tollgate and surrounding villages. The practice holds a General Medical Services (GMS) contract and provides GP services commissioned by NHS North East Essex Clinical Commissioning Group.

The practice is managed by two GP partners, two salaried GPs, one female GP registrar. The practice occasional takes students who are training to work in the health service, including trainee doctors and student nurses. Nursing staff include a nurse practitioner, a practice nurse who work part time and two healthcare assistants. The practice also employs a practice manager, reception staff, secretaries and administration staff.

The practice is open from 8.30am to 1pm and 2pm to 6.30pm on weekdays, with extended hours on a Tuesday until 7.30pm GP appointments are available between 9am and 11.50 am, and between 2pm and 6.20pm. Routine appointments can be pre-booked up to two weeks in advance in person, by telephone or online. Home visits and telephone consultations are available daily as required.

The practice has opted out of providing GP services to patients outside of normal working hours such as evenings and weekends. During these times GP services are provided by Harmoni, an out-of-hours advice, emergency and non-emergency treatment service. Details of how to access out-of-hours advice and treatment is available within the practice, on the practice website and in the practice leaflet.

Why we carried out this inspection

We inspected Tollgate Surgery 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?

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
- 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 this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included North East Essex Clinical Commissioning Group (CCG) and the NHS England Area Team. We carried out an announced visit on 22 June 2015. We sent CQC comment cards to the practice. We received 12 completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with three of the GPs, a practice nurse, a healthcare assistant, the practice manager and several support staff. We also spoke with nine patients, two of whom were members of the patient participation group and senior staff from six local care homes where patients registered with the practice lived.

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. There were procedures in the practice for dealing with alerts and significant events. This required staff to record any incident or situation sufficiently that presented potential risks to patients to warrant a permanent record, and perhaps with the potential to prompt learning or change. We saw systems and processes to identify risks and improve patient safety were robust. All practice staff were aware of how to report safety incidents and near misses that occurred. Staff understood the need to report significant events. Safety alerts were passed onto all staff in line with the practice policy and in a systematic manner. We saw minutes from practice meetings that showed evidence of shared learning in relation to complaints.

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 records of nine significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. There was some evidence that the practice had learned from these 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.

There was evidence that the practice staff had learnt from significant events. The significant event protocol detailed the outcomes of significant event reporting to include; learning from the event as a team and operate and discuss incidents in an open environment. We were told that clinical and practice meetings were held and we saw records of these. There was no documented evidence that learning related to clinical matters was discussed. However staff told us they were aware of incidents and they were discussed openly and honestly at meetings; but they could not identify any changes that had been made as an outcome of the investigations.

National patient safety alerts were disseminated by the practice intranet to practice staff. 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 at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all clinical staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share 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 GP lead in safeguarding vulnerable adults and children. We were told that they had been trained to level three in safeguarding children, which is the required level. The GPs we spoke with could demonstrate they had the knowledge to enable them to fulfil this role. Not all the staff we spoke with were aware who the lead GP was, but all staff told us they would speak to the practice manager or one of the GPs if they had a safeguarding concern.

There was a chaperone policy, and notices informing patients of this service were displayed in the practice. (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). We were told by the practice manager that health care assistants acted as a chaperone. Staff we spoke with who acted as a chaperone were able to confirm this and described the training they received. For example, where to stand to be able to observe the examination. We spoke with the practice manager who told us all clinical staff had undergone criminal records checks. The level of criminal records checks undertaken is dependent on the type of work and an enhanced DBS provides additional checks to help identify whether people are suitable to work with children and vulnerable adults.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a 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 fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

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.

Systems were in place to check medicines were within their expiry date and suitable for use and all the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. However, we found that blank prescription pads were not logged or audited so that risks of misuse were minimised.

The GPs discussed the arrangements for the management of high risk medicines which may have serious side-effects. GPs told us that patients who were prescribed these medicines had regular blood tests carried out and that these were reviewed when authorising repeat prescriptions.

All prescriptions were reviewed and signed by a GP before they were given to the patient.

Cleanliness and infection control

Patients we spoke with during the inspection told us that they found the practice was always clean and that they had no concerns. We observed the premises to be visibly clean and tidy. Hand sanitising gels were available for patient use. Hand washing sinks with liquid soap, sanitising gel and paper towel dispensers were available in treatment rooms and toilet facilities, as were posters promoting good hand hygiene. We saw records to confirm that patient disposable privacy curtains were changed on a regular basis. We saw that the practice had arrangements to segregate and safely store clinical waste including disposable instruments and needles at the point of generation until it was safely disposed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Sharps bins were sited correctly, signed and dated.

Clinical staff had received inoculations against the risk of Hepatitis B and it was also offered to non-clinical staff. The effectiveness of this was monitored through blood tests. Clinical waste was handled correctly and a waste management contractor had been appointed to collect it on a regular basis. It was being stored safely prior to collection.

The practice had undertaken a risk assessment for legionella and had assessed the risk to be low.

Equipment

Staff we spoke with told us they had sufficient quantities of equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly.

All portable electrical equipment was routinely tested and records we viewed reflected that this had been taking place. The latest testing took place in October 2014. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and blood/sugar testing equipment for patients with diabetes. Calibration testing had been booked for this year and was due to take place in the near future.

Staff told us that when equipment was running low an effective system was in place for re-order so they did not run out of important equipment. They said the practice was pro-active in ensuring they had the right equipment to do their job.

Staffing and recruitment

Good

Are services safe?

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the 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).

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which staff were required to read as part of their induction which was accessible on the intranet for all staff. One of the nurse practitioners at the practice was the identified health and safety lead and staff we spoke with knew who this was.

Identified risks were included on a risk register maintained by the practice manager and graded risks as low, moderate and high. Each risk was assessed, graded and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at practice meetings. For example, the receptionists identified that patients queuing for reception were within earshot of the patients conversing with the receptionist and they were able to overhear confidential discussions. It was decided to have a free standing sign away from the desk and request patients to wait until called. On the day of the inspection we saw this system in practice.

The practice used an assessment tool to identify patients at highest risk of attending A&E or being admitted to hospital. These were reviewed on a monthly basis. Staff were therefore able to identify and respond to changing risks to patients including deteriorating health. For example, the practice kept a register of patients most likely to attend A&E and the top 2% of their most vulnerable had alerts on their records so that they were prioritised when they contacted the practice. Staff would also follow up on attendance and results when patients in this group where referred for tests and medical procedures. This ensured they were able to inform GP's when patients had not attended for tests.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed all staff were up to date in basic life support training. The practice had an easily accessible resuscitation bag equipped with oxygen and airway devices. An automated external defibrillator (AED) with child and adult pads was available. An AED is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Emergency medicines were stored with the resuscitation equipment and included medicines for management of cardiac arrest, anaphylaxis, chest pain, seizures and asthma attacks. All emergency medicines were in date and expiry dates were checked weekly by the practice nurse.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. A copy of the plan was available

Good

Are services safe?

in every clinical room; it was updated every six months or when there was a change identified. The registered manager and practice manager kept copies off site for reference.

Staff working at the practice were required to undertake fire safety and evacuation procedures. We were told that a fire drill had been practised in November 2014 and staff members confirmed this with us. Fire alarm servicing had been undertaken and the equipment was found to be in working order. A fire drill protocol was in place and fire extinguishers were in date and suitably placed allowing easy access for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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 saw the practice had direct computer links to NICE and other guidelines and clinicians told us they found this much more practical and allows clinicians to access up to date evidence based care in a timely fashion. We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw the practice had

monthly clinical meetings where new guidelines were disseminated, the implications for the practice's

performance and patients were discussed and required actions agreed. The GPs and nurses told us they completed thorough assessments of patients' needs and these were reviewed when appropriate in line with NICE guidelines.

There were leads for all specialist clinical areas such as chronic obstructive pulmonary disease (COPD) palliative care, diabetes and asthma. The practice nurses who were the leads for diabetes and COPD had completed additional specialist training courses in regards to managing patients with these conditions and clinics were held for the practice patients. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw that where a clinician had concerns they would electronically 'instant message' another clinician to get a second opinion.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these 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. For example, patients with diabetes were having regular health checks identified by the 'new year of care' guidance. The patients at Tollgate Health Centre had the facility to be referred by the GP to a care adviser. The Adviser assisted patients to access different services; for example to support their mobility needs and access to food banks and welfare benefits.

Patients with long term conditions and those approaching the end of their lives through illness had their needs assessed and were provided with effective care and treatment. Registers were in place and other healthcare professionals were involved in assessing their needs and planning their care. Patients and their carers/families were signposted to support from external organisations, such as Macmillan nurses and social services.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with all staff 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. Patients told us they had never experienced any discrimination at the practice.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, summarising patients' records, managing child and adult protection alerts and medicines management. Information was shared widely with staff and other healthcare professionals.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from QOF. QOF is a national performance measurement tool. For example we saw an audit regarding patients taking a particular anti-inflammatory painkiller following a medicines management alert about prescribing non-steroidal anti-inflammatory drugs (NSAIDS). The practice reviewed all patients using this medication and showed us data evidencing a decrease in the numbers of prescriptions for most patients which lowered the risk of harm to patients due to medicines interactions.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question.

Good

Are services effective?

(for example, treatment is effective)

Where they continued to prescribe it, they outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a system in place for carrying out clinical audits, a process by which practices can demonstrate ongoing quality improvement and effective care. We saw that a number of completed and actioned clinical audits had been carried out including one which monitored patients with type 2 diabetes and associated chronic kidney disease. The results of the audit showed that these patients' blood pressure was being controlled in line with NICE guidelines. Other clinical audits were conducted around identifying patients who were at greater risks of developing a disorder or cancer as a result of long term medication use. Following the audits alternative medicines were prescribed where appropriate and the rationale for continued use was recorded where this occurred.

Effective staffing

We looked at training records of practice staffing included medical, nursing, managerial and administrative staff. We reviewed five staff training records and saw that all staff were up to date with their annual basic life support training but two non clinical staff members had not received safeguarding training for adults or children.

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

With the exception of the practice manager, staff had annual appraisals which 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. For example, one of the health care assistants had requested further training in chronic wound management. The practice had encouraged and arranged this and the health care assistant had developed her role in wound dressings.

The practice was a teaching practice where trainee GPs worked on a rotation basis for a number of months. We spoke with one registrar and four trainee GPs who told us they were supported by all of the senior GPs at the practice. A system was in place where they could consult a more senior GP during surgery hours if they were unsure of any issue. They said that their performance was the subject of regular review and that advice and guidance was always available. Part of the process was regular meetings with one of the GPs who had been allocated to them as a mentor.

The trainee GPs told us that the support mechanism in place was very useful to them as they had the opportunity to discuss consultations and undertake case studies to improve their skills and give them valuable experience. They told us that they would be happy to work at the practice once qualified.

Working with colleagues and other services

The practice worked with other service providers, including social services, the local hospital trust and community services to meet patients' needs and support patients with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X-ray results, letters including hospital discharge, out – of - hour's providers and the 111 summaries were reviewed and actioned on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were slightly raised at 16% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings six weekly for those patients with long-term conditions, end of life care needs or children on the at risk register. These meetings were attended by a variety of other healthcare

Good

Are services effective?

(for example, treatment is effective)

professionals including district nurses, social workers, and palliative care nurses. The needs of patients were discussed individually and decisions about care planning were documented.

The practice provided GP care to older people living in six local care homes and a residential setting for people with learning disabilities. Senior staff at those homes confirmed that the practice worked with them closely. This included providing telephone cover as a first point of contact so that care home staff could seek advice for a GP who knew patients at the home well.

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 ambulance and out-of-hours services.

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by October 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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.

Consent to care and treatment

The practice had a policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions themselves. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Staff told us the practice had provided training to staff about the MCA which was supported by written guidance to refer to. Some staff had also completed external MCA training at the same time as a safeguarding vulnerable adults course.

The practice team understood the importance of considering patients' ability to make informed decisions about their care and treatment and give consent for this. We found that there was good communication between the GPs, nurses and healthcare assistants to help ensure patients and their carers received the support they needed according to their individual circumstances. The practice used care plans to support patients with a learning disability and those living with dementia to make decisions about their care and treatment.

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) and had a section stating the patient's preferences for treatment and decisions. 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).

Health promotion and prevention

The practice nurses, and healthcare assistants provided appointments for a range of health checks and conditions. These included women's health, blood tests, health checks, baby immunisations and health reviews for patients with long term conditions such as diabetes or respiratory problems. Patients were offered support to stop smoking by the practice nurses. There was no set day for this so patients could book appointments which were convenient for them. The practice also provided phlebotomy (taking blood samples), electrocardiograms (ECGs) and spirometry (a spirometer measures the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function).

Patients we spoke with confirmed that they were invited for relevant health checks and one of the practice nurses provided diet and obesity management advice. New patient checks included screening for alcohol related problems. The practice had an informative website which provided links to news and information about a wide range of health and care topics.

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

Good

Are services effective?

(for example, treatment is effective)

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. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. However, whilst the practice provided chlamydia screening on request staff told us they us they encouraged patients to attend the local specialist clinic where they could receive specialist advice, education and signposting to other relevant services.

The practice had 55 people on their learning disabilities register and 44 had had their yearly review in 2014. Staff clearly recorded in the patient's records reasons why a patient did not have an annual review, for example refusal.

To provide flexibility for working parents, appointments for childhood immunisations were available throughout the week as well as at a weekly baby clinic run by the practice nurses. Childhood immunisation rates were in line with the CCG average. The practice was proactive in encouraging patients to have annual flu vaccinations.

The practice nurses were responsible for the practice's cervical screening programme. The data available showed that the take up of screening at the practice was in line with the national average. Patients could also have long acting contraceptive devices and implants provided at the practice at appointment times to suit them.

The practice website contained links to NHS travel health information and patients could book appointments for travel vaccinations with the practice nurses on days and times convenient to them.

The nurses told us they frequently put patients in touch with other organisations which might benefit their health and wellbeing. These included healthy living initiatives at the local leisure centre and schools, a 'Men at Work' project and Age UK.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We gathered patients' views by looking at 12 Care Quality Commission (CQC) comment cards patients had filled in. On the day of the inspection we spoke with nine patients two of whom were members of the practice's patient participation groups (PPG). A PPG is a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

Information from patients we spoke with and from the comment cards gave a positive picture of their experiences. Several patients described the service they received as being excellent and described the staff team as professional, caring and pleasant. In some of the comment cards patients highlighted that their GP listened to them and took and gave them enough time during appointments. Patients were also complimentary about the helpfulness of reception staff that recognised and accommodated their individual needs when they visited the practice. One comment card stated staff always went the extra mile to accommodate them.

We spoke with senior staff from six local care homes where some of the practice's patients lived. They described the service provided by the practice as helpful, supportive and professional and the approach of the GPs as compassionate. They were very satisfied with the care and treatment patients received and highlighted the caring approach the GPs also took to patients families.

The evidence from all 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 published in January 2015, showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 87% and national average of 89%.
- 88% said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 98% said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 92% and national average of 92%.
- 96% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 92% and national average of 91%.

Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. 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 follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 87% of respondents to the national GP patient survey 2015 said they found the receptionists at the practice helpful compared to the CCG average of 85% and national average of 87%.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

Good

Are services caring?

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:

- 87% said the last GP they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 84% and national average of 85%
- 83% 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%.
- 88% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received 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:

- 88% said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.
- 96% 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. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice had a register of patients with mental health support and care needs. Each person on the register was invited for an annual review of their overall health. The team had been proactive in identifying patients who may be living with dementia and had a dementia register. GPs told us that they reviewed these patients' needs annually.

The practice used the gold standard framework for end of life care and had a register of patients receiving palliative care. The practice discussed these patients at weekly meetings and took part in weekly meetings with other professionals involved in caring for patients in these circumstances. They had a clear system for making sure members of the team, including reception staff and those who answered the telephones, were aware of patients who were at the end of their lives and might need an urgent response from the team. The practice provided information about patients in these circumstances to local out of hours and ambulance services when the practice was closed.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

Tackling inequity and promoting equality

The practice building was purpose and was accessible to patients with mobility difficulties as facilities were all on one level. There were automatic entrance doors to make it easier for patients with mobility difficulties and families with prams and pushchairs to get in and out of the building. The building had been designed with wide corridors to assist patients who used wheelchairs. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The practice had its own car park with spaces for patients with disabilities.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

Information about opening hours and appointment times was available on the practice website and the practice leaflet. The practice's reception opening hours were 8.30am to 6pm Monday to Friday; they closed from 1pm to 2pm for lunch and training. Late evening clinic were held on Tuesday with pre-bookable appointments up until 7.30pm. Open surgery for patients was Monday to Friday 8.30am to 10.00am. There were also pre-bookable appointments available with GPs and nurses each morning and afternoon, and with the health care assistant each morning.

The national GP patient survey 2015 information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 78% were satisfied with the practice's opening hours compared to the CCG average of 73% and national average of 75%.
- 79% described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%.
- 91% said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be

Good

Are services responsive to people's needs?

(for example, to feedback?)

their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking two weeks in advance.

The practice provided information about out of hours arrangements on their website and in a leaflet available in the practice. The out of hours service in Colchester was run by an organisation called Harmoni and was based beside Colchester Hospital.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. This included a complaints procedure, a detailed complaints leaflet for patients as well as basic information on the practice website and in the main practice leaflet.

The practice manager held the lead responsibility for complaints handling and patients were asked to contact them with any concerns. The practice's processes for complaints were in line with contractual obligations for GPs in England.

We saw evidence to show that the practice discussed concerns and complaints at team meetings and used these to help them improve the service. We saw evidence that the practice had responded to complaints and addressed these but we identified that the written records of discussions with the staff team could be more detailed. This would help the practice when they audited complaints and reviewed progress towards any necessary improvements.

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. The practice's presentation at the start of the inspection showed that they had a firm grasp on their future aims and a desire to continually improve and develop. The practice had business planning arrangements and these were reviewed every month.

The practice had a statement of purpose which promoted a caring and responsive service with good outcomes for patients. The GPs had a clear vision to deliver high quality care and promote good outcomes for patients. We found there were no documented practice values but GPs told us they led by example to be caring, conscientious, concerned and efficient. Staff knew their responsibilities towards patients and other practice staff. All staff we spoke with shared this objective/aspiration. GPs and the practice manager met regularly with the Clinical Commissioning Group (CCG) to discuss current performance issues and how to adapt the service to meet the demands of local people. The GPs and nurses were committed to providing a high quality service to patients in a fair an open manner.

Governance arrangements

The GP partners and nurses all had lead roles and specific areas of interest and expertise. These roles included specific lead roles at the practice such as reviewing guidance from the National Institute for Health and Care Excellence (NICE), minor surgery, safeguarding, learning disability, dementia and prescribing. Some of the GPs also played lead roles in non-clinical areas such as finance and human resources. They were engaged with the wider local medical community and attended Clinical Commissioning Group (CCG) meetings and some were actively involved in the Local Medical Committee (LMC).

The practice had policies and procedures to support the effective management of the practice. These were available for all staff on the practice's computer system. Most staff referred to this at some stage during our discussions with them. All the members of the team we met understood their roles and responsibilities within the practice.

We saw examples of clinical audit cycles which demonstrated that the practice reviewed and evaluated the care and treatment patients received.

We saw detailed meeting minutes from several forums. They provided evidence that all relevant issues were discussed, actions raised and assigned and learning disseminated to appropriate staff. Staff told us they thought communication within the practice was usually good and the meeting minutes provided evidence of this.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary scheme that financially rewards practices for the provision of quality care to drive further improvements in the delivery of clinical care. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes. We saw evidence that there was good sharing of the latest guidelines and protocols and necessary changes to clinical practice were also discussed.

Risks were assessed and effectively managed through quality assurance and governance arrangements. By effectively monitoring and responding to risk patients and staff were being kept safe from harm.

Leadership, openness and transparency

The practice team was positive about working together for the future. Staff we spoke with were positive about working at the practice which they described as patient focussed. They told us the team were close, supportive, and inclusive and they felt valued. The healthcare team had good staff retention and they attributed this to the close and supportive team members. Staff said they could approach the GPs and management team and one member of staff gave us an example of asking a GP for advice about a patient earlier that day.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did.

Seeking and acting on feedback from patients, public and staff

The practice had a well-established patient participation groups (PPG). A PPG is a group of patients registered with a

Are services well-led?

Good

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

practice who work with the practice team to improve services and the quality of care.. During the inspection we met representatives from the PPG. One member told us the practice viewed the PPG as a 'critical friend' and that the practice manager and a GP always attended the meetings.

The PPG representatives gave us examples of improvements the practice had made in response to the PPG recommendations and other sources of information. For example, the practice had seen comments on NHS Choices criticising the practice regarding access to appointments on Mondays. The practice had not waited for the PPG to raise this concern but had recruited an additional member of reception staff to assist with answering the phones. Another improvement was that staff now let patients know if their GP was running late.

The practice and the PPG were working together to raise the profile of the PPG and this included developing regular newsletters and maintaining a designated noticeboard within the patient waiting area. The PPG and practice were aware that the profile of the PPG did not match the practice population and were looking at ways to encourage a more diverse mix of patients to become involved. On the day of the inspection the PPG had set up an area to promote the PPG and actively encourage patients to get involved.

Throughout the inspection members of the team told us they felt supported. They said the partners and practice management team were approachable and that they felt valued and listened to. None of the staff we spoke with had any anxieties about raising concerns.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Staff told us they received the training necessary for them to carry out their duties and they were able to access additional training to enhance their roles. Their personnel files contained details of the training courses they had attended. Most staff told us they were supported in their personal development.

The nurses were able to obtain clinical advice from any of the GPs at the practice, and they supported them in their appraisals and in their continuing professional development (CPD). GPs told us the lead nurse also helped with the CPD of the other nurses and health care assistants.

All staff had an annual appraisal with their line manager. We saw staff had a personal development plan in place and their on-going learning had been discussed.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), indicated that they were up to date and fit to practice. The GPs and practice nurses regularly attended meetings with the CCG so that support and good practice could be shared.