Creffield Medical Centre

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Creffield Medical Centre is a six partner medical practice located in a residential area of Colchester. The practice provides primary medical services for approximately 12,000 patients living in Colchester and the surrounding area. The practice is established as a GP training practice.

Creffield Medical Centre is operated by six partners, one salaried general practitioner (GP), four GP registrars (trainee GPs), a practice manager, four practice nurses, two nursing assistants, a phlebotomist and administration staff. It has strong relationships with the community nursing staff, health visitors and midwives.

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

Patients and relatives made positive comments about their experience of using the practice, the treatment they received and their involvement in this.

Patients told us that clinical and reception staff were pleasant, helpful and any issues were dealt with in a timely manner. All patients we spoke with, and those who completed our comment cards, told us that they were treated with dignity and respect. They said that their treatments were explained fully and their consent was obtained before treatment started.

We found that the practice provided effective treatment based on relevant guidelines. The practice was responsive to the changing needs of their patient population.

There were robust systems in place ensuring that patients were treated safely and that risks to their health, safety and welfare were recognised and well managed. There were systems for recognising patients who may be vulnerable, and for considering how to best treat and monitor these patients so as to ensure that they received safe and effective care and treatment.

There was an open culture within the practice which encouraged staff and patients to report incidents, concerns and to make comment on how the service could be improved. Patients and staff we spoke with told us that their comments were well received. They told us that changes had been made to improve the service and patients experience where suggestions had been made.

The practice was well managed. Staff we spoke with were aware of the leadership arrangements and individual team member's roles and responsibilities. The practice used a variety of clinical and non-clinical audits to improve the outcomes for patients across all population groups.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
The service was safe.

The practice had a consistent track record on patient safety. Complaints and concerns were dealt with in an open and transparent way, and learning from incidents was shared with staff. Arrangements were in place to identify patients who may be vulnerable and to protect them from possible harm or abuse.

The premises were well maintained and there was sufficient suitable equipment to assess and treat patients. The premises were clean and there were arrangements to protect patients against the risk of infection.

Medicines, including those for use in medical emergencies were available, in date and stored appropriately. Although some needles and sterile wipes were out of date these were disposed of at the time of our inspection. Patients' medicines were reviewed appropriately and patients were provided with information about the medicines prescribed for them.

There were stringent systems for recruiting new staff and there were sufficient numbers of clinical and non-clinical staff to meet patients' needs.

Are services effective?
The service was effective.

Care and treatment was delivered in line with current best practice. Staff were appropriately qualified and had opportunities to develop their skills and knowledge. The practice worked closely with other providers to co-ordinate care.

Information and advice was provided around diet, exercise, smoking cessation and alcohol intake, to promote and encourage patients to choose healthy life-style options. The practice participated in national screening programmes to help identify and prevent conditions such as diabetes, cervical cancer and the other preventable conditions.

Are services caring?
The practice was caring.

Summary of findings

Patients and carers we spoke with described the service provided as excellent or very good. People felt their views were listened to and were respected. People told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect by both the clinical and non-clinical staff.

The practice had an established patient participation group. This was a group of patient representatives who met regularly with doctors, nurses and administrative staff to discuss changes affecting how the practice was managed and any areas for improvement.

The GP Patient Survey from 2013 and NHS Choices data showed that people felt the doctors and nurses treated them with care and respect.

We saw when people did not have the capacity to consent, the practice acted in accordance with the legal requirements.

Are services responsive to people's needs?

The practice was responsive to people's needs.

The practice was organised so as to meet patients' needs. Staff at the practice understood the needs of the practice population and made reasonable adjustments according to the individual needs of patients.

The premises were accessible to those with a physical and sensory disability. Patients had the option to book appointments over the telephone or on-line. The practice offered telephone consultations or face to face appointments depending on each patient's preference or need.

There was a clear complaints policy and procedure. All complaints were well received, investigated and responded to promptly. Complaints were discussed at weekly staff meetings and areas for improvement where identified were shared with staff so that there was learning from any concerns raised by patients.

Are services well-led?

The service was well led.

There was a clear leadership structure and allocation of responsibilities. There was an open and supportive culture. Patients and staff told us that they were involved in influencing how the practice was managed.

There was a system of audits and risk management in place to ensure patient, staff and visitor safety. There was a governance strategy in place and the practice understood how they needed to take forward the practice in the future.

Summary of findings

There was a commitment to learn from feedback, complaints and incidents. There was an emphasis on management seeking to learn from stakeholders, in particular through the patient participation.

Summary of findings

The six population groups and what we found

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

Older people
The practice recognised the needs of older patients and had established links with other health and social care professionals, such as, district nurse teams and local care home providers, so as to ensure older patients received safe, effective and co-ordinated care to meet their needs.

People with long-term conditions
The practice had effective systems in place to monitor patients with one or more chronic conditions. The practice was involved in a national programme to improve access to patients with long-term conditions by reducing the numbers of appointments these patients had to make for review and treatment of their condition.

Mothers, babies, children and young people
The practice had effective arrangements in place to offer access to co-ordinated care for mothers, babies and young children. The practice had a flexible appointments system and clinical staff were aware of consent and capacity principles and how to apply these.

The working-age population and those recently retired
The practice had considered the needs of working-age patients and offered flexible access to the service, including Saturday appointments, telephone consultations and access to appointments, and arranging repeat prescriptions via the internet.

People in vulnerable circumstances who may have poor access to primary care
The practice had arrangements in place to ensure access to its services by patients who were vulnerable as a result of social or other circumstances, such as certain medical or mental health conditions and learning disabilities, people who were homeless or from travelling communities or migrant populations.

People experiencing poor mental health
The practice had systems in place to offer support to people with mental health conditions. Staff treated people sensitively and were aware of their responsibilities for raising concerns such as missed appointments.

Summary of findings

What people who use the service say

During our inspection we spoke with 22 patients, including two representatives from the Patient Participation Group. The Patient Participation Group was a patient and staff forum which met to discuss ways in which the service could be improved for patients. We also spoke, during our inspection, with three carers and reviewed comments made by four patients who completed our comment cards prior to our visit. We also spoke with staff from three care homes which the practice provided a service to.

All the patients we spoke with and those who completed our comment cards made positive comments about the service and treatment that they received. They told us that felt they had good access to appointments and that they generally were able to see their own doctor. Patients said that their care and treatments were explained to them in a way that they could understand and that they were involved in making decisions.

Patients told us that they had no concerns or complaints about the practice and they felt confident that any concerns would be handled appropriately. They said that they were treated with respect and kindness by all staff.

Staff from local care homes where people were patients at the practice told us that regular visits were made to review patients care and treatment. They also confirmed that doctors attended promptly when a patient's condition deteriorated and that they received advice as needed by telephone contact with the practice.

Areas for improvement

Action the service COULD take to improve

The recording in respect of checks in relation to equipment for use in a medical emergency could be improved to ensure that all of the checks were carried out appropriately.

The practice could consider reviewing the use of rectal diazepam in the treatment of seizures as other more suitable medicines are available.

Good practice

Our inspection team highlighted the following areas of good practice:

There was a weekly fitness and exercise class, for older people, held at the practice.

Creffield Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a second CQC inspector, an expert by experience and a practice manager.

Background to Creffield Medical Centre

Creffield Medical Centre is a large surgery located near to Colchester Hospital. The surgery provides a primary medical service to approximately 12,000 patients from Colchester.

Approximately 7,000 of patients registered at the practice comprised people aged between 19 and 64 years. Older people accounted for 2,700 of patients and approximately 4,600 patients registered at the practice were living with long-term chronic conditions. The area has low numbers of people from ethnic minorities, homeless people and people from travelling communities.

Creffield Medical Centre is a G.P training practice. It provides training to G.P registrars (trainees).

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information, including information we held about the surgery and other information that was publically available. We also asked other organisations to share their information about the surgery. Before our inspection we spoke with representatives from two care homes where patients were registered with the practice. People living at the care homes included people with dementia.

During our inspection we spoke with 22 patients who used the surgery, including older people, working age, people with long-term conditions and mothers. We also spoke with three people who were carers for their relatives who were registered at the practice.

Detailed findings

We received and reviewed four comments cards, which we had left for patients to complete prior to our inspection. We spoke with 12 members of staff.

We carried out an announced visit on 04 June 2014. During our visit we spoke with a range of staff, including: doctors, nurse practitioners, nurses, reception staff and administration staff.

We spoke with two members of the Patient Participation Group (PPG) during our inspection. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

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

A comments box with comment cards was left for approximately two weeks in the waiting area. We received four comments cards which we reviewed during our visit in order to inform our inspection.

Are services safe?

Summary of findings

The service was safe.

The practice had a consistent track record on patient safety. Complaints and concerns were dealt with in an open and transparent way, and learning from incidents was shared with staff. Arrangements were in place to identify patients who may be vulnerable and to protect them from possible harm or abuse.

The premises were well maintained and there was sufficient suitable equipment to assess and treat patients. The premises were clean and there were arrangements to protect patients against the risk of infection.

Medicines, including those for use in medical emergencies were available, in date and stored appropriately. Although some needles and sterile wipes were out of date these were disposed of at the time of our inspection. Patients' medicines were reviewed appropriately and patients were provided with information about the medicines prescribed for them.

There were stringent systems for recruiting new staff and there were sufficient numbers of clinical and non-clinical staff to meet patients' needs.

Our findings

Safe patient care

The practice had a consistent track record on safety. The practice scored well across all quality indicators such as Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK, introduced in 2004 as part of the General Medical Services Contract, rewarding them for how well they care for patients.

We saw that where concerns arose they were addressed in a timely way. There were effective arrangements in place for reporting safety incidents. Staff told us that they felt confident and were supported to report any concerns, incidents or 'near misses'. The staff we spoke with were all able to accurately describe the process they would follow if they witnessed any safety incidents or other concerns.

From a review of the significant events analysis we saw that all serious incidents were fully investigated and recorded, and were subject to a significant events audit. There were monthly significant events audit meetings where ongoing investigations were reviewed. There was an annual review of any serious or significant events, and information was shared internally with staff and other external agencies as appropriate.

Learning from incidents

Creffield Medical Centre had an open and transparent culture when dealing with incidents where things went wrong or where there were near misses. Staff we spoke with reported that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved. We reviewed the significant events that had occurred in the service. We saw that they had been documented and discussed, and learning and action points had been identified. Staff who were involved in each significant event were included in the significant event analysis and learning was shared. We saw evidence that the actions identified had been followed up and completed.

There were weekly doctors' meetings, which included a review of any accidents, incidents and complaints. From these any action points for learning were shared with all members of staff and follow up actions were reviewed to ensure that they had been completed. From a review of the

minutes of these meetings we saw that learning from incidents was also discussed at all staff meetings to ensure that information was shared with all members of clinical and non-clinical staff as needed.

Safeguarding

We saw the practice had safeguarding policies in place for both children and vulnerable adults. These were reviewed annually or more frequently, if required, to ensure that they reflected current local and national guidelines. All clinical and non-clinical staff undertook safeguarding adults and children training, which was updated every three years. There was a nominated GP who was the lead for safeguarding who had oversight for procedures and practices. Staff we spoke with could describe how they would deal with any concerns they had about the safety or welfare of patients. They told us that they would report their concerns initially to the safeguarding lead, or another doctor in their absence. Staff were aware that they could report concerns to the local social services safeguarding team.

The practice had a system to highlight vulnerable patients on their computerised records system. This information was available on patient records when they contacted the practice, attended, or failed to attend appointments so that staff could be aware of any issues. There were guidelines for staff to follow when patients who had been identified as vulnerable, either due to social circumstances or as a result of a mental health condition or learning disability failed to attend appointments. Staff were aware of their responsibilities to follow up on missed appointments by patients who were deemed to be vulnerable, including contact with carers, offering a second appointment with a time limited response and, where appropriate, carrying out urgent home visits or making referrals to social service or the local safeguarding team.

The patients we spoke with told us they felt safe at the practice. They told us that they were well cared for, that they felt safe and had no concerns about the practice. We saw that there were leaflets available to patients about organisations that they could contact if they had concerns about their safety or that of someone close to them.

The doctors and practice manager we asked demonstrated a robust understanding of their safeguarding responsibilities and ways to identify potentially vulnerable patients, including those new to the practice. They told us the patient would have a registration medical with the practice nurse. In addition, any records from a patient's former practice(s) would be sent to the practice. Nominated members of the administration team were responsible for summarising patient paper medical records onto the electronic computer system when people registered at the practice so that information about each patient's past and present medical history could be accessed easily. There were clear guidelines for staff to follow when summarising patients' records. They were audited by the doctors to monitor the quality of data added to patient records to minimise the risk of errors in coding information.

Monitoring safety and responding to risk

The practice had systems and arrangements in place for dealing with emergency situations including medical emergencies and outbreak of fire. The practice was situated within close proximity to Colchester Hospital and staff told us that in the event of a medical emergency they would call the emergency services, who could attend within minutes. Resuscitation equipment, including defibrillator (an electrical device that provides a shock to the heart when there is a life threatening erratic beating of the heart in some cases of cardiac arrest) and emergency oxygen was available.

Medication was available for managing medical emergencies such as anaphylaxis (a severe allergic reaction). We saw that emergency medicines were within the expiry date. Staff we spoke with were unclear as to who was responsible for checking the defibrillator and no checks were recorded. All nursing and medical staff undertook cardiopulmonary resuscitation (CPR) training, which was updated every 18 months. The practice used rectal diazepam for the treatment of seizures. At the time of our visit there was no rectal diazepam available in the emergency medicines store. Rectal diazepam is used to treat people during epileptic seizures. The practice manager told us that this had been ordered.

We saw that medicines and equipment for use in medical emergencies were stored in various areas within the practice. For example, the defibrillator was located at the reception desk. Emergency medicines were stored in a dedicated emergency medicines cupboard in the nurse's treatment room. All of the emergency medicines and equipment were located on the ground floor. Staff we spoke with were aware of the medical emergency procedure and where medicines and equipment were

Are services safe?

located. However as there were no emergency medicines or equipment available on the first floor where the doctors consulting rooms were located, and the equipment and medicines were stored in separate areas, this could cause delays in getting the appropriate equipment and medicines to the consulting rooms should they be needed.

The practice had a staff rota that set minimum staffing levels and these were reviewed weekly or more frequently if needed. As part of the continuity plan there were arrangements for increasing staffing levels to manage increased demand for services.

We saw clear procedures were in place for anticipating and responding to risks. There were risk management plans and assessments. These covered risk assessments around the use of equipment such as passenger lift, and hazardous substances such as chemical cleaning agents.

The practice employed a buildings manager who was available during opening hours between Monday and Friday. They had oversight for the safe management of the premises. There were risk management systems to identify and manage risks and these were reviewed annually.

There were reviews of health and safety risk assessments and fire safety audits. With saw evidence of fire emergency plans and staff told us they had regular fire drills.

Medicines management

There was a supply of medicines on site for use in an emergency or for administration during a consultation (for example, vaccinations). We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date. Some needles and sterile alcohol wipes were found to be past their expiry date. Medicines were stored securely and at the appropriate temperature to ensure their effectiveness. For example, vaccines are required to be stored below a certain temperature. We asked the nursing staff how they ensured the vaccines were stored appropriately. They described the 'cold chain process' whereby the vaccines were delivered in a cool box then immediately transferred to a fridge. The temperature of the fridge was checked daily to ensure it was within the correct range.

Patients we spoke with told us they were given information about any prescribed medication such as side-effects and any contra-indications (adverse interactions between certain medicines and other substances such as food, alcohol or other medicines). They told us that their medicines were reviewed and any changes were explained fully

Cleanliness and infection control

We observed that all areas within the practice were visibly clean. Hand washing facilities were available at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Staff had access to policies and procedures around cleaning and protecting people from the risks of health care acquired infections.

The practice employed a contract cleaning company for general cleaning of the premises. Cleaning checklists, which described the areas and frequency for cleaning, were available. Monthly 'spot checks' were carried out to monitor cleaning and regular infection control audits, which included checking premises and equipment for cleanliness, were carried out. We viewed the most recent infection control audit for the practice. We saw that any areas where improvements were identified that these had been addressed.

The practice had a named member of staff who took the lead on infection control. From the staff training matrix and through discussion with staff we saw that all staff undertook training in infection control, which was updated every two years. Staff had access to appropriate personal protective equipment, including disposable gloves and aprons. All clinical staff underwent screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations or provide evidence of their immunity so as to minimise risks of blood borne infections.

We saw there were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades We noted that all of the bins were lined with colour coded bin liners, according to the type of waste being disposed of. The practice had a service level agreement with a waste disposal company and waste awaiting collection was stored securely.

Staffing and recruitment

The practice manager and doctors we spoke with told us that staffing levels for the practice were reviewed each week and there were minimum levels set, which were

Are services safe?

reviewed and planned for in advance to take into account planned absences due to holiday or training leave. The staff rota confirmed this. The practice manager told us that there was rarely a need for the use of locum doctors and that, where needed, two locum doctors who were familiar with the practice were employed so as to help ensure continuity of the service provided.

Dealing with Emergencies

The practice had systems and protocols in place to ensure business continuity in the event of any emergency, for example, power failure or flood. These were regularly reviewed so as to ensure that they remained relevant and reflected any newly identified risks. We looked at the business contingency plan and saw that it considered arrangements in place to respond to changes in demand for the service, for example, extreme weather or outbreak of infectious diseases such as influenza and any seasonal demands which may impact on the demand for patient appointments

The practice had fire safety risk management plans to deal with the outbreak of fire. Fire zones were clearly signposted as were for evacuation routes from the premises. The practice had a named fire marshal and staff had undertaken fire safety training, which was updated every two years.

Equipment

Equipment used for assessing and treating patients, such as blood pressure and blood glucose monitoring equipment were regularly checked, calibrated (adjusted, if necessary, to ensure accurate results for patients)and serviced in line with manufactures' guidelines so as to ensure that they were working properly.

The premises were easily accessible to people with limited mobility and the practice had equipment available to support people, including a passenger lift. There were self-check in facilities available at the entrance to the practice and the equipment to do this was positioned so that it was accessible to patients in wheelchairs.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

Care and treatment was delivered in line with current best practice. Staff were appropriately qualified and had opportunities to develop their skills and knowledge. The practice worked closely with other providers to co-ordinate care.

Information and advice was provided around diet, exercise, smoking cessation and alcohol intake to promote and encourage patients to choose healthy life-style options. The practice participated in national screening programmes practice to help identify and prevent conditions such as diabetes, cervical cancer and the reoccurrence of other longer term illness.

Our findings

Promoting best practice

We talked with four GPs who were knowledgeable about their patient needs. Care and treatment was delivered in line with recognised best practice standards such as National Institute for Health and Care Excellence (NICE) guidance. One of the doctors had a lead role in palliative and end of life care. They told us that the practice used a local 'advanced care planning' initiative. Booklets were given to elderly patients or those with palliative conditions or chronic diseases and deteriorating health. These provided information to help them to plan and prepare for their future care and practical arrangements and make decisions before they became terminally ill. We found patients who had a terminal illness or long-term health condition were discussed at bi-monthly palliative care meetings. Macmillan nurses and community nurses were invited to discuss how care could be improved, and monitoring that consideration had been given to patients preferred place of care. There were arrangements for discussing and making do not attempt cardiopulmonary resuscitation (DNAR) decisions where treatment would be inappropriate.

The practice was involved in the productive general practice programme and in particular the shaping our future practice programme and we saw that they had developed a template for reviewing patients with multiple chronic illnesses in one appointment. This would help to improve continuity of care and reduce the number of appointments patients needed to attend.

The practice carried out internal audits to ensure people with long term conditions were reviewed. We looked at some of the audits and saw that, patients identified with a long term condition, such as, diabetes or asthma, were placed on disease registers and regular review appointments were made with the nurses in accordance with best practice guidance.

Management, monitoring and improving outcomes for people

Delivery of care and treatment achieved positive outcomes for people. We reviewed the most recent QOF scores for the practice. The quality and outcomes framework (QOF) is part

Are services effective?

(for example, treatment is effective)

of the General Medical Services (GMS) contract for general practices. Practices are rewarded for the provision of quality care. The practice's overall score for the clinical indicators was higher than the local and national average.

We saw that the practice scored highly and performed well in preventing people from dying prematurely, enhancing quality of life for people with long term conditions, helping people to recover from illness or following injury, ensuring people have a positive experience of care and, treating and caring for people in a safe environment. For example, the practice had fewer emergency cancer admissions, and fewer accident and emergency admissions compared to the national average. The practice participated in clinical audits and peer review, which led to improvements in clinical care. Clinical audits and peer review are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the weekly GPs meetings.

Complete, accurate and timely performance information was published by the practice. This included the results of the patient survey and the subsequent action plan.

Staffing

The practice had a process in place for recruiting staff to work at the practice. This set out the procedures and checks to be carried out for all candidates and new staff. There was a job description and person specification for each role and evidence of selection and grading at interview. One new member of staff we spoke with confirmed they had completed a written application, attended a formal interview and that they were completing an induction period where they were mentored and supported by named staff.

We looked at a sample set of seven of recruitment files. We saw recruitment checks had been undertaken, which included a check of the person's skills and experience through the curriculum vitae (CV), and identification was confirmed. Checks were undertaken for GPs and nurses to ensure their fitness to practice, for example, checking General Medical Council (GMC) registration for doctors and Nursing and Midwifery Council (NMC) for nurses. Enhanced Disclosure and Barring Service (DBS) checks were undertaken for clinical staff that were in contact with patients to ensure their suitability to work with vulnerable adults and children. A small number of administrative and clerical staff had been employed at the practice for over 15 years references or DBS checks were not recorded in these staff files. The practice manager told us that DBS checks would be obtained.

The practice had a programme of core staff training with refresher updates planned, scheduled and monitored so as to help ensure that staff had appropriate training to deliver safe and effective care and treatment. We looked at the staff training matrix and staff we spoke with confirmed that they had opportunities for professional development beyond mandatory training.

Training and development needs were identified through annual appraisal of staff performance and personal development plans. We saw that where staff had identified training interests that arrangements had been made to provide suitable courses and opportunities for staff. This training also enabled staff to maintain registration with their professional bodies such as the General Medical Council for doctors and Nursing and Midwifery Council for nurses.

There were effective induction programmes in place for all staff, including locums. We found there were comprehensive induction packs for each role within the practice. Creffield Medical Centre was a training practice for registrar (trainee) GP's. We spoke with one of the four GP registrars and they told us that they received support and mentorship. They said that the practice had a very good reputation among training practices. Doctors we spoke with showed commitment to external training sessions such as the local Clinical Commissioning Groups (CCG) learning needs course and other online training and courses. There were arrangements for staff appraisal and doctor peer review to ensure that appropriate standards were maintained.

Working with other services

The doctors worked closely with other health and social care providers, to co-ordinate care and meet people's needs. The practice safeguarding lead had good relationships with social services, health visitors and school nurse services.

The practice maintained a palliative care register. We looked at the minutes from the bi-monthly meetings which

Are services effective?

(for example, treatment is effective)

were attended by the clinical team and the Macmillan nurses. We saw there were procedures in place to inform the local out of hours service about any patients on a palliative care pathway.

There were robust arrangements for working with the local out of hour's service to ensure that information about treatment and risks was handled appropriately. We saw that where patients were seen by the out of hours service in the evenings or at weekends, information about the treatment patient's received was reviewed by doctors at the practice to ensure that any issues were followed up in a timely way.

Staff at local care homes where people were patients at the practice reported that doctors were proactive in reviewing and treating patients. They said that weekly visits were made to review new and existing patients, and that domiciliary visits were easy to arrange to see patients whose health deteriorated.

Health, promotion and prevention

The practice manager, doctors and nursing staff told us that new patients on regular medicines were routinely seen by a doctor. They said that other patients were offered an initial assessment appointment with a nurse or health care assistant. The doctors reviewed the assessments and where appropriate patients were invited in for an appointment with the doctor. Carers were identified during the initial assessment and advice given about support agencies. We saw records that showed the practice participated in national screening programmes to help identify and prevent conditions such as diabetes, cervical cancer and other preventable conditions.

There was a range of health promotion leaflets available in the waiting area with information to promote good health and lifestyle choices. Information available included advice on diet, smoking cessation, alcohol consumption, contraception. Sexual health and smoking cessation sessions were provided. There were also leaflets signposting patients to other local and national support and advice agencies.

The practice held an exercise and balance class weekly for older people. Classes were held on the day of the inspection and patients we spoke with told us that they found this service to be very beneficial.

Are services caring?

Summary of findings

The practice was caring.

Patients and carers we spoke with described the service provided as excellent or very good. People felt their views were listened to and were respected. People told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect by both the clinical and non-clinical staff.

The practice had an established patient participation group that met regularly with doctors, nurses and administrative staff to discuss changes affecting how the practice was managed and any areas for improvement.

The GP Patient Survey from 2013 and NHS Choices data showed that people felt the doctors and nurses treated them with care and respect.

We saw where people did not have the capacity to consent, the practice acted in accordance with the legal requirements.

Our findings

Respect, dignity, compassion and empathy

We spoke with 22 patients who used the practice and three relatives who were caring for patients at home. They described the service provided as very good or excellent. Patients said that staff were caring and compassionate and they felt their views were listened to and respected. People who were caring for relatives praised the support that they had received and the care provided to their relatives. Both patients and relatives commented that the doctors were caring and understanding of their needs. There were a variety of information leaflets in the waiting area signposting patients and carers to local and national support agencies such as the British Red Cross, bereavement services, Mind and Macmillan counselling services.

Before the inspection took place we had asked people who used the service to complete comment cards. We received four completed cards. The comments were all positive and patients who completed these praised the doctors, nurses and reception staff for their helpfulness and caring attitude.

We reviewed the NHS Choices data and saw that the practice scored 4.5 star rating out of a possible 5 stars for patient satisfaction around dignity and respect. We also looked at the results of the 2013 GP patient survey. Over 200 patients completed the survey. Of those, 92.8% described their overall satisfaction with their visit as good or better.

During our inspection we observed the waiting area, and saw staff greeted and responded to patients in a caring way. For example, we saw that reception staff took time to offer information and advice in a helpful and friendly way. We saw staff supported patients to check in for their appointment and offer apologies where patients had to wait longer than anticipated for an appointment. The waiting area was open plan and there were notices at the reception desk informing patients that they could request a private room to discuss any personal issues.

Staff were aware of how to respect people's privacy and dignity. Consultations took place in purpose designed rooms with an appropriate couch for examinations and curtains to protect privacy and dignity. Patients told us that on occasions they were asked if student doctors could be present during consultations as part of their training, and

Are services caring?

that their wishes in respect of this were respected. They also said that they had been able to choose a male or female doctor according to their preferences. There were five male and six female doctors working at the practice. There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations.

Involvement in decisions and consent

We saw there were a variety of patient information leaflets and notices on display throughout the practice. These included information on health conditions, health promotion and screening, and support groups.

Patients told us they felt they had been involved in decisions about their care and treatment. They said they were given verbal and written information about their illness and the treatment they received. Patients told us that nursing and medical staff explained their care and treatments, and answered any questions they had in a way that they could understand.

The practice had policies and procedures in place for obtaining patients' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. There was reference to Fraser guidelines when assessing whether children under sixteen were mature enough to make decisions without parental consent. Fraser guidelines and the revised Department of Health (2004) guidance for health professionals, states that children under 16 years can be legally competent if they have 'sufficient understanding and maturity to enable them to understand fully what is proposed'.

There were procedures in place, in line with the Mental Capacity Act (2005) around treating people who lacked capacity to make decisions in relation to their care and treatment. We spoke with three doctors and they were aware of their responsibilities in making best interests decisions relating to providing suitable treatments where patients lacked capacity to make decisions.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs.

The practice was organised so as to meet patients' needs. Staff at the practice understood the needs of the practice population and made reasonable adjustments according to the individual needs of patients. The service had arrangements in place to ensure that it could meet patient needs.

The premises were accessible to those with a physical disability. Patients had the option to book appointments over the telephone or on-line. The practice offered telephone consultations or face to face appointments depending on each patient's preference or need.

There was a clear complaints policy and complaints were well received, investigated and responded to promptly.

Our findings

Responding to and meeting people's needs

The practice was accessible to patients with mobility difficulties. The waiting area was large and open plan, situated on the ground floor. Nurse consulting rooms were situated on the ground floor. The doctors' consulting rooms were situated on the first floor and were accessible via a passenger lift. There were suitable toilet facilities for people with mobility difficulties. There was some limited free parking available in a car park directly outside the building. We saw there were marked bays for patients with mobility difficulties. Staff at the practice were aware of the issues posed to patients due to the lack of parking spaces and were working with members of the Patient Participation Group to identify ways to improve these facilities. The Patient Participation Group was a forum made up of patient representatives and staff who met regularly to discuss changes within the practice and how services could be improved for patients.

Staff who worked at the practice spoke a number of foreign languages including Afrikaans, Urdu, Hindi and French. Staff told us that patient information could be translated into a number of languages as required. Printed information was available at the reception desk in large print format if requested. This was not signposted so that patients would know where to access this.

The practice manager told us how the practice understood the different needs of the population it served and acted on these to design services. The practice was involved in the national shaping the future, productive general practice programme. They had developed a template for reviewing patients with multiple chronic conditions at one appointment so as to reduce the numbers of appointments for patients with more than one long term condition and improve continuity of care and treatment.

Access to the service

Creffield Medical Centre was open between 08.30 and 18.30 Monday to Friday and pre-booked appointments were available on Saturdays between 08.15 and 11.15. The out of hours service was carried out by a local provider and information about how to access this service was found in the practice information leaflet and the practice website. Appointments could be made in advance by telephone or over the internet. Appointments made on the day were split between telephone and face-to- face consultations.

Are services responsive to people's needs?

(for example, to feedback?)

Patients were encouraged to access telephone consultations unless they required an examination by a doctor so as to improve the service offered to all patients. The practice had found that the use of telephone consultation had enabled doctors to provide an extra 100 patient appointments each week. One patient we spoke with told us that they were impressed at the speed at which they had received their telephone consultation and told us that they were very impressed with the service.

The practice had a duty doctor system and this doctor was available each day to prioritise patients with urgent medical problems or those who were unable to make an appointment with their regular doctor. The duty doctor carried out telephone consultations to provide advice, make appointments or signpost patients to more appropriate services.

The majority of the 22 patients we spoke with told us that there were no difficulties in making appointments and that they were usually able to get an appointment that suited them. They told us that there were generally no problems making same day appointments, especially for children when they telephoned the surgery between 08.00 and 08.30. Patient's told us that staff were really helpful and that it was usually easy to get an appointment that suited their needs.

The appointments system and the staffing numbers were reviewed weekly to ensure the practice was operating effectively and where issues were found the appointment system had been amended. In 2013 a telephone triage system was introduced. However the practice manager and patients we spoke with told us that patients expressed dissatisfaction with the system and it was discontinued. Staff told us that there was a meeting each Monday morning to discuss appointments provision in the previous week and to plan for the current week.

We received feedback from the managers at two local care homes where people living there were patients at the practice. The managers told us that staff were very approachable and helpful. The manager of one home told us that GPs attended weekly visits to review new and existing patients. They told us that there were never any problems arranging visits or getting advice on the telephone.

The practice had a clear, easy to navigate website which contained detailed information to support patients including the arrangements for making and cancelling appointments, requesting and accessing repeat prescriptions and obtaining blood results.

Concerns and complaints

We saw there was a detailed complaints policy in place. This was contained in the practice leaflet and was available on the practice's website. A number of patients we spoke with told us that they were unaware of the practice's complaints procedure and that they had not been provided with a complaints leaflet. They told us that they did not have any complaints about the practice and they felt confident that they could raise concerns or complaints with any member of staff and that these would be addressed appropriately.

Staff we spoke with were aware of the complaints policy. They told us they would deal with minor matters straight away, but would inform the practice manager of any complaints made to them. This meant patients would be supported to make a complaint or comment if they wanted to. We spoke with the practice manager who told us that one written complaint had been received in 2014. This had been fully and thoroughly investigated and a response sent to the complainant. Issues raised in the complaint had been shared with all members of staff as was learning points to help minimise recurrence.

The practice manager told us that informal or verbal complaints were dealt with as soon as they were raised and that these were recorded in a daily communication book. A monthly meeting was held to review any complaints received within the previous month so as to help identify any trends in areas of the service that resulted in complaints.

Are services well-led?

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

Summary of findings

The service was well-led.

A clear leadership structure was in place with clear allocation of responsibilities. There was an open and supportive culture. Patients and staff told us that they were involved in influencing how the practice was managed.

There was a system of audits and risk management in place to ensure patient, staff and visitor safety. There was a governance strategy in place and the practice understood how they needed to take forward the practice in the future.

There was a commitment to learn from feedback, complaints and incidents. There was an emphasis on management seeking to learn from stakeholders, in particular through the patient participation.

Our findings

Leadership and culture

Creffield Medical Centre is a large practice with 10 doctors. There was a well-established management structure with clear allocations of responsibilities. Each of the doctors had leadership roles, for example, named doctors were responsible for palliative care, GP training and safeguarding. Staff we spoke with were aware of their responsibilities and those of other members of the team. Staff told us that the culture within the practice was open and supportive.

We spoke with five GPs and one trainee GP. They all demonstrated a clear understanding of their area of responsibility. Each person took an active role in ensuring that a high quality service was provided to the patients.

Governance arrangements

The practice had a structured policy for governance arrangements which included overseeing and managing risks, patient experience and involvement, clinical audit and improvement. Governance responsibility was shared between the practice manager and the GP partners, with clearly identified lead roles and responsibilities. There were robust systems in place to identify risks such as appointment availability and GP cover arrangements.

Systems to monitor and improve quality and improvement

We found the practice manager and partners held regular practice meetings and this included reviewing the register of all accidents/incidents and significant events which had taken place, including lessons learned from them. There were also on-going checks of the safe running of the practice such as legionella testing, infection control monitoring and fire safety.

The practice manager and clinicians were aware of the needs of the practice population and tailored the service to meet the needs of the local population groups. Some improvements were needed to effectively monitor and improve the quality of service, for example there was some inconsistent recording in the checking and auditing of medicines and equipment such as needles.

We were told the GPs received external peer reviews through their annual appraisals.

Are services well-led?

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

Patient experience and involvement

The practice had a Patient Participation Group (PPG) with approximately 30 representatives. The Patient Participation Group was a forum made up of patient representatives and staff who met regularly to discuss changes within the practice and how services could be improved for patients.

We spoke with two members of the group. They told us that staff were very receptive to suggestions and comments, and that they never dismissed anything offhand. They told us that any issues raised would be taken back and discussed with the practice partners and that actions and outcomes would be discussed at the next meeting. An example of positive action taken as a result of comments made included a visit by the pharmacist following concerns that the on-site pharmacy did not always have stocks of regularly prescribed medicines. The group members reported that following the meeting these issues had been addressed. Where patients wished to be involved but were unable to attend meetings, information was available on the practice website and emails were sent to patients. The patient participation group had developed a patient survey questionnaire with input from patients about the questions that they felt were relevant when making comments about the service that they received at the practice.

The minutes from the group's meeting were available on the practice website, as was information inviting people to join the group. We saw that the group was active in encouraging people to join, particularly from younger age groups, ethnic minorities and carers who were under-represented. We saw from the minutes that improvements were on-going or planned, such as, suggestions to deal with the limited parking facilities at the practice, and improving the practice website.

Patients we spoke with told us that they felt their comments and suggestions were well received and they said that they were very satisfied with the services and treatment they received at the practice. We saw examples of where the management of the practice had been changes and improved as a result of comments made by patients. For example, when patients expressed dissatisfaction with the telephone triage system this was discontinued.

Staff engagement and involvement

All of the practice staff met regularly. We looked at the minutes from various weekly meetings, including a practice meeting attended by the doctors and practice management team each Monday to review how the appointments system had worked the previous week and any issues, complaints or incidents. There were weekly and monthly clinical team meetings to discuss complex clinical diagnosis or management issues. Information and learning from any issues discussed were fed back to staff.

The practice had robust whistleblowing procedures and a detailed policy in place. Staff we spoke with were all able to explain how they would report any such concerns. They were all confident that concerns would be acted upon.

All clinical and non-clinical staff we spoke with reported that they were encouraged and supported to be involved in discussion about how the practice was managed. They told us that they felt valued and that there was an open and transparent culture within the practice.

Learning and improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patients' experience and to deliver high quality, safe and effective care. We saw that there were robust arrangements for learning from incidents, significant and serious events and complaints. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

Identification and management of risk

The practice had systems in place for anticipating and assessing risks to the safety and welfare of patients and staff. This helped to ensure that any risks to the delivery of high quality care were identified and mitigated before they became issues which adversely impacted on the quality of care. Staff we spoke with were aware of their individual responsibilities around identifying and reporting areas of risk. Staff told us that they knew who to report any issues to within the team dependant on individuals' responsibilities.

Risks were discussed at the regular weekly and monthly practice meeting; any action taken or necessary was documented and cascaded to all staff.

Older people

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

Summary of findings

The practice recognised the needs of older patients and had established links with other health and social care professionals, such as, district nurse teams and local care home providers so as to ensure that older patients received safe, effective and co-ordinated care to meet their needs.

Our findings

Approximately 2,700 of the 12,000 patients registered at Creffield Medical Centre were over 65 years. The practice was proactive in providing access to services for this population group. Saturday appointments were available to assist patients who relied on family members to escort them to appointments, and who may not be available to do so during the working week.

The practice provided a reliable service to patients who were living in local care homes. A weekly visit was made to assess new patients and carry out reviews of existing patients. Staff we spoke with from two care homes told us that they could easily access assistance and advice over the telephone if a patient's health deteriorated and that home visits were always carried out when requested.

The practice was proactive in responding to the Department of Health initiative to ensure that older people have a named GP. Letters were sent to this patient group and handed out during appointments and at flu vaccination sessions to help ensure that all patients in this population group were contacted.

The practice held weekly balance and exercise classes at the surgery and patients we spoke with told us that they found this service very beneficial.

People with long term conditions

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

Summary of findings

The practice had effective systems in place to monitor patients with one or more chronic conditions. The practice was involved in a national programme to improve access to patients with long-term conditions by reducing the numbers of appointments these patients had to make for review and treatment of their condition.

Our findings

The practice had arrangements for reviewing and auditing the care and treatment provided for patients with chronic or long-term conditions, such as, diabetes. Patients' attendance for medication reviews were monitored and followed up where patients failed to attend their appointments.

On-going clinical audits were used to improve outcomes for patients with long-term conditions. The practice was involved in a national programme to improve access to patients with long-term conditions. This was by reducing the numbers of appointments these patients had to make for review and treatment of their condition.

Mothers, babies, children and young people

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

Summary of findings

The practice had effective arrangements in place to offer access to co-ordinated care for mothers, babies and young children. The practice had a flexible appointments system and clinical staff were aware of consent and capacity principles and how to apply these.

Our findings

The practice had suitable arrangements in place for providing access to patients from this population group. Patients we spoke with told us that doctors and nurses were very understanding of their needs and that it was always possible to get same day appointments when their children were unwell.

The clinical staff we spoke with had a good awareness of principles of consent for under 16 year olds.

The surgery had a system in place for monitoring uptake of childhood vaccination.

Doctors we spoke with told us that in the event of a child suffering a cardiac or pulmonary arrest that they would be taken immediately to Colchester Hospital Accident and Emergency department, which was nearby.

Working age people (and those recently retired)

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

Summary of findings

The practice had considered the needs of working-age patients and offered flexible access to the service, including Saturday appointments, telephone consultations and access to appointments and arranging repeat prescriptions via the internet.

Our findings

Patients we spoke with told us that they were able to get emergency appointments and appointments for routine reviews, and screening such as cervical smear tests relatively easily. They told us that they were aware that the practice had appointments on Saturday mornings and telephone consultations for advice.

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

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

Summary of findings

The practice had arrangements in place to ensure access to its services by patients who were vulnerable as a result of social or other circumstances, such as certain medical or mental health conditions and learning disabilities, people who were homeless or from travelling communities or migrant populations.

Our findings

The premises were accessible to those with a physical and sensory disability. Nurse consulting rooms were situated on the ground floor. The doctors' consulting rooms were situated on the first floor and were accessible via a passenger lift. There were suitable toilet facilities for people with mobility difficulties.

The practice had 41 patients who had a diagnosed learning disability registered at the practice. There were arrangements in place to ensure that these patients had an annual health review and check-up. These were undertaken by one of the nurse practitioners, who had undergone training in supporting people with learning and communication difficulties.

The practice had 'easy read' letters sent to patients with learning disabilities to invite them to attend appointments and these were followed up with telephone calls to help ensure that patients understood the content of the letters and attended appointments.

People experiencing poor mental health

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

Summary of findings

The practice had systems in place to offer support to people with mental health conditions. Staff treated people sensitively and were aware of their responsibilities for raising concerns such as missed appointments.

Our findings

We found that the practice had an effective system for identifying patients with mental health needs so that when they contacted the surgery for an appointment or when they attended for routine reviews they would be seen by the clinical staff best placed to support them.

Reception and administrative staff told us that where patients with mental health conditions failed to attend appointments that there were arrangements for raising with the doctors and making second appointments, or arranging home visits if necessary.

The practice had a range of information leaflets available about local support agencies available to people who have mental health conditions.