Dr N A Turner and Partners

Quality Report

The Medical Centre,
Church Road,
Tiptree,
Colchester,
Essex
CO5 OHB
Tel: 01621 816475
Website: www.tiptree-medcentre.co.uk/

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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

Tiptree Medical Centre provides primary medical services for approximately 11,000 patients living in Tiptree and the surrounding area.

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

We found that there were systems in place to ensure patient safety. These included a business contingency plan in the event of a non-clinical emergency, structures for handling clinical emergencies, a clear medicines management system and, robust child and adult safeguarding processes.

The practice made use of best practice guidelines, learning from significant events analysis and national bench marking systems to provide effective care. They also developed systems, such as, monitoring uptake of child vaccinations and health promotion activities to improve patient outcomes and mitigate risks.

Most patients we spoke with felt involved in the treatment process and thought that staff had a good attitude. We saw reception staff dealing with difficult situations with empathy and respect.

There could be more robust systems in place to identify those patients who are also carers and to consider the impact that their medical history/treatment will have on them and those they care for.

We found that the practice was aware of the needs of the different population groups and tried to ensure that all population groups had equal access to services provided. However written information was not easily available in a variety of formats which may affect access for some groups of patients.

There were issues both historically and currently with access to appointments. However the practice had worked hard to try to resolve these and was able to show that changes they had made had positive outcomes for patients.

There was an audit structure in place but this could be more robust.

Patients and staff were able to raise concerns or make suggestions and we saw that these were investigated and action taken.

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.

Patients told us that they felt safe. We found that when concerns arose they were addressed. Learning took place from the outcome of any incidents or safety alerts.

The practice had a system in place for the storage and disposal of medicines. There was appropriate and sufficient emergency medical equipment. The practice had plans in place to deal with non-clinical emergencies that may interrupt the running of the service.

Are services effective?
The service was effective.

We found that clinical audit and best practice guidelines, as well as significant events analysis were discussed in meetings and used to improve the service provided to patients. Staff received training according to their interests, to provide both career progression and offer additional services for patients.

We found there was evidence of collaboration with other health care professional but improvements could be made with this. There was a system in place for ensuring the uptake of childhood vaccinations especially for those in more vulnerable circumstances.

Are services caring?
The service was caring.

We found that patient's privacy and dignity was respected. There were limited systems in place to identify patients who were also carers and how their health impacted on the people they cared for. Patients and their representatives were involved in consultations so that they could make an informed choice about their care.

Are services responsive to people's needs?
The service was responsive.

Patients we spoke with felt involved in their treatment and listened to.

The practice had systems in place to ensure that the most vulnerable patients had equal access to services. Consideration could be made to how to provide easily available information to

Summary of findings

patients in different formats. The availability of appointments had been reviewed. Systems were put in place to reduce the pressure on clinical appointments by offering a range of access options, for example, with a nurse or telephone consultations.

We found that there was a complaints system in place. Complaints were responded to in a timely manner and resolved where possible to the complainant's satisfaction.

Are services well-led?

The service was well-led.

All staff were aware of their own and others roles and responsibilities within the practice. There was a clear leadership structure in place. We found that there were systems in place to monitor and improve the quality of service provision, however some of these could be developed further to be more robust. There was a commitment from all staff to learning through review and analysis of incidents.

The practice encouraged patient involvement and feedback however patients did not always engage in this process. The practice had forecast future patient needs and considered this in their contingency plans to deliver a sustainable service.

Summary of findings

The six population groups and what we found

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

Older people
The practice had systems in place to aid older patients to access the service. Patients may experience difficulties accessing the car park during very heavy rain due to the localised flooding of this area.

A new local enhanced service to prevent unplanned hospital admissions would mean that some patients in this population group would have their care case managed in order to reduce the likelihood of an unplanned hospital admission.

People with long-term conditions
There was a structure in place to ensure that patients with long-term conditions were monitored and reviewed. There was effective co-operation with other health care professionals to provide co-ordinated care.

Mothers, babies, children and young people
We found there were systems in place to monitor the uptake of childhood immunisations.

Smoking cessation sessions were available to pregnant women, mothers and young people.

At the time of our inspection there were no representatives from this population group on the Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

The working-age population and those recently retired
The practice had reviewed its opening hours to ensure the service was accessible to those patients of working age. There was on-going work related to access outside of normal practice hours.

This population group had the largest representation on the Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

People in vulnerable circumstances who may have poor access to primary care
We found that the practice understood the needs of patients with learning disabilities.

Summary of findings

The practice attracted temporary patients during harvest time as people came to work in the area. These patients had access to the full range of general medical services. We saw that the practice had systems in place to engage vulnerable members of the Gypsy community.	
People experiencing poor mental health We found that the practice provided support to people experiencing poor mental health. We found through observation of staff interactions and through talking with staff that staff had a sensitive and compassionate approach to dealing with this group of patients and their relatives/carers.	

Summary of findings

What people who use the service say

Most patients we spoke with told us that they felt safe in the service. Two patients reported quality care with satisfactory treatment outcomes for them. One patient was dissatisfied with the treatment they were receiving as they felt the treatment process should be accelerated to provide relief sooner. However, most patients we spoke with were positive about staff's attitude and told us that they felt involved in their care.

There was no agreement amongst the patients we spoke with regarding suitability and availability of appointments to patients or if this had improved with telephone consultations and greater use of the nursing team access. Some patients found access to appointments in the mornings to be easy; others tried the telephone but ended up attending in person. Patients who accessed the service via the website and online booking felt this was okay if you used it regularly and could remember the password.

Areas for improvement

Action the service COULD take to improve

The practice could improve the security of the clinical waste bins location, which although locked were unsecured.

The practice could develop a more robust structure around clinical audits and their review. This would ensure that they were gaining the most benefit from them and could evidence good patient outcomes as a result.

The practice could review their system for checking emergency equipment, to ensure that all equipment is in date.

Dr N A Turner and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and a GP. The team included a CQC inspector and a variety of specialists: a Practice manager and an Expert by Experience. An Expert by Experience is a person who has experience of using a service either themselves or as a carer for someone using the service.

Background to Dr N A Turner and Partners

Tiptree Medical Centre is located in the heart of the busy village of Tiptree and provides primary medical services for approximately 11,000 patients. Patients are accepted on the register from Tiptree, Kelvedon, Feering, Messing, Inworth, Great Totham, Tolleshunt Knights and Tolleshunt D'arcy.

The village is also home to the Tiptree jam factory and during harvesting time the practice numbers are increased by temporary patients who come to assist with the fruit picking.

The Colchester area, which Tiptree is situated in, has a significantly higher than average percentage of the population aged 65 years and older, compared to the England average. Only 7.8% of the population belong to a non-white minority. The Tiptree area is also home to a Gypsy population.

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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information, some we had requested from the practice, some information we held about the practice and other information that was publically available. We also asked other organisations to share their information about the practice.

Detailed findings

We carried out an announced visit on 02 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 four patients who used the service, a local pharmacist and a manager from a care home for people with learning disabilities.

We spoke with two members of the Patient Participation Group (PPG). 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 we reviewed after the visit.

We provided the practice with a comment box to be placed in the waiting area for patients to complete a comment card on their experiences of the service. During our visit we encouraged patients to provide their feedback, however none of the comments cards were completed.

Are services safe?

Summary of findings

The service was safe.

Patients told us that they felt safe. We found that when concerns arose they were addressed. Learning took place from the outcome of any incidents or safety alerts.

The practice had a system in place for the storage and disposal of medicines. There was appropriate and sufficient emergency medical equipment. The practice had plans in place to deal with non-clinical emergencies that may interrupt the running of the service.

Our findings

Safe patient care

We found that the practice tracked their performance both overall, through national and local standards reporting, and as a result of incident reporting and complaints. The practice was aware of some areas where their performance, such as for patient satisfaction, was not at the same level as other practices within the area. We saw during our inspection that these issues either had been or were being addressed. Where concerns were raised they were investigated, practices reviewed and changes made, where appropriate, to mitigate the risk of reoccurrences.

Staff we spoke with were aware of their roles and responsibilities in reporting incidents relating to patient safety. Events that may affect patient care were identified and investigated in a timely manner.

Learning from incidents

We found that the practice completed significant events analysis. Through discussions with staff, we found that the outcome of these was discussed and disseminated amongst the other staff in the surgery in order for lessons to be learned and improvements to be made. Staff told us that they talked about what went wrong, what they could do better and what they had learnt from the incident.

We spoke with nursing staff who told us that on receipt of national or local safety alerts, for instance relating to medications information, staff were made aware of them and the issues were discussed in peer meetings.

Safeguarding

We spoke with three patients who all told us that they felt safe within the service.

We found there were systems in place for the safeguarding and protecting of vulnerable adults and children. These included having a named GP partner as safeguarding lead and all GPs having the number for the child safeguarding team programmed into their mobile telephones.

We looked at the systems in place for ensuring that immunisations and other medicines stored at the correct temperature and were in date. We found that there was a comprehensive checking system in place. This is important as the effectiveness of medicines stored outside of the recommended temperature limits and/or out of date, can be greatly reduced.

Are services safe?

Monitoring safety and responding to risk

We saw that there was emergency clinical equipment stored within easy access of all clinic rooms and the waiting area. We found that the oxygen cylinder was in date and an emergency bag was available. We saw that although there was resuscitation equipment in the emergency bag that was in date, some was out of date. This included items such as nebuliser components, airways and children's oxygen masks. This could affect the integrity of the item.

We found the skill mix amongst the staff was well thought out and there were systems to maintain this at all times. This was achieved through a flexible cover system using part-time staff so that experienced staff were always available to support safe, effective care.

Medicines management

We looked at the systems in place for the safe handling, storage and disposal of medicines. This included those medicines categorised as controlled drugs which are subject to stricter protocols. We found that controlled drugs (CDs) were kept securely with two key holders. We found that all medications checked were in date, with the exception of two ampoules which had only just passed their expiry date and were removed that day. Expired CDs were kept securely until a representative from the Clinical Commissioning Group (CCG) disposed of them. We saw that systems were in place for the tracking of medicines which were in line with recommendations from the Royal Pharmaceutical Society.

The practice had recently introduced 56 day prescriptions for some patients. These types of prescriptions were not used for patients on new medicines. Patients in receipt of the longer prescriptions were closely monitored by a named GP and a second GP to oversee the safe prescribing and management of the medication.

Cleanliness and infection control

We saw that all areas of the practice looked visibly clean. There was hand gel available for staff and patients to use in the communal areas promoting hand hygiene. The practice had a contract with an external cleaner to complete cleaning of the general areas within the service. Staff would complete a daily check on this although the checks were not recorded or audited. Each nurse had responsibility for identified clinical areas and their responsibilities included changing the disposable curtains in the clinic rooms, cleaning equipment and ensuring that the children's toys in the waiting room were kept clean. This showed that the practice had systems in place to reduce the risk of spread of infection.

We found that the practice had appropriate clinical and general waste disposal systems. Clinical waste bins were located in an alleyway; these was locked but was not secured behind locked doors or gates. Therefore there was a risk that clinical waste could be accessed and cross-contamination occur.

Staffing and recruitment

Nursing staff had developed specialist clinical areas in order to maintain and review patients with specific conditions. More than one nurse was skilled in a particular specialist area, for example diabetes, to provide support if the other nurse was unavailable. GP staff told us that they were aware of the risk of the GPs becoming deskilled in these areas therefore they attended training to ensure their own skills were kept up to date.

In situations where staff were off on leave, the practice use of part-time staff or those who had previously worked in the practice ensured that the staff providing cover were well trained and aware of the local systems.

Dealing with Emergencies

The practice had in place a business contingency plan to anticipate any foreseeable emergency situations, including loss of staff, issues with premises and with information technology. The plan included access to Clinical Commissioning Group premises in an emergency. The practice had involved relevant agencies in their planning for emergencies.

During our inspection there was a particular heavy rain storm which flooded a large proportion of the car park. The car park drained within a few hours of flooding. We spoke with the practice regarding this and the measures that they had taken to prevent this. The practice has had the drains pumped out and investigated and when necessary in the past has closed the car park. They have also received a quote for long term work to be done to resolve the issue. However, at the time of our inspection, this was not financially viable.

Equipment

There was sufficient safe and maintained equipment on the premises, including equipment for use in an emergency situation.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

We found that clinical audit and best practice guidelines, as well as significant events analysis were discussed in meetings and used to improve the service provided to patients. Staff received training according to their interests, to provide both career progression and offer additional services for patients.

We found there was evidence of collaboration with other health care professional but improvements could be made with this. There was a system in place for ensuring the uptake of childhood vaccinations especially for those in more vulnerable circumstances.

Our findings

Promoting best practice

GPs told us that during monthly practice meetings they participated in discussions on clinical cases and National Institute for Health and Care Excellence (NICE) guidelines. We saw use of NICE guidelines for some clinical conditions during our inspection.

GPs and nursing staff we spoke with regarding consent had a robust understanding of this. The manager of a local care home for people with learning disabilities told us that the practice staff involved people even though they have the most severe spectrum of disorders.

We saw that as part of their appraisal cycle GPs reviewed the care and treatment of groups of patients through clinical audit. We viewed the recent audits completed. We found that for one audit where the outcome was for an action to take place this had not yet been completed despite the audit being six months old.

Management, monitoring and improving outcomes for people

The practice used outcomes of significant events analysis to learn lessons and improve service provision. The practice also used information from national data collection and comparison to identify areas to improve. For example, access to appointments and patient satisfaction was identified as an issue for the practice. The practice had looked into different solutions to this issue, including a drop in phlebotomy service, a drop in minor ailments clinic and online appointments booking. They were continuing to monitor and improve this outcome for patients as they were aware issues still existed.

Staffing

We viewed five staff files and saw that there were effective recruitment and selection processes in place. Appropriate checks had been undertaken before staff began work. People had been through an interview process to assess their suitability and experience for the role. We saw that Disclosure and Barring Service checks (DBS replaced the Criminal Records Bureau or CRB) had been carried out, references taken up and identity checked. All staff had a photo identity smart card to access computer systems. Issue of these smart cards is subject to rigorous checks.

Are services effective?

(for example, treatment is effective)

Although not all four staff files contained copies of the recruitment checks, the provider maintained records of documentation for the smart card checks which would contain this information.

Tiptree Medical Centre provides training placements for student nurses. This helped ensure that nursing staff were kept up to date with latest skills and training available.

We found that staff had undertaken training and updates appropriate to their role. We were told by the practice manager that they recognised how important reception staff were to the experience the patients received of the practice. Therefore staff were supported to undertake a National Vocational Qualification (NVQ) in subjects like customer satisfaction and management according to their individual wishes and needs. Staff confirmed they had received training to perform their roles. Other staff had been given opportunities to train as phlebotomists and one member of staff was being supported to access training to be a paramedic. We saw that staff were given opportunities for development beyond the training required by the practice and showed that the practice valued its staff.

Working with other services

We spoke with the GP partners who told us that the practice took part in multi-disciplinary meetings with district nurses and other health care professionals for patients with palliative care needs. This assisted them to plan and co-ordinated individualised care. All patients receiving, or needing to receive palliative care would be discussed including those with Chronic Obstructive Pulmonary Disease (COPD), heart failure, cancer and those patients who had died since the previous meeting.

We spoke with a local Pharmacist who told us that significant events relating to medicines were shared with them. We found that sometimes changes to prescriptions were not effectively communicated to them by the practice and this could be improved.

During conversations with nursing staff we found that relationships with both health visitors and district nurses could be improved as they did not meet and could sometimes be difficult to contact.

The practice offered referrals to other practices for patients requiring minor surgery, such as basal cell carcinoma removal.

We found there were systems in place to ensure communication between out of hours providers and the practice. Information relating to patients with complex needs and those on end of life care were available for the out of hours service to view. This information included contact information, special notes, and the patients resuscitation status. This was intended to support the continuity of care for patients between the services.

Health, promotion and prevention

The practice had an established immunisation follow up process in place to ensure robust uptake of the immunisation programme. For the practice's more vulnerable population groups, which may be less likely to access services, for example, babies and children from minority communities such as the Gypsy community, there were additional triggers in place to try to engage these groups in the child immunisation programme.

Patients were also able to self refer into these services by booking appointments on line.

There was a weekly smoking cessation service provided by the Stop Smoking group, where people could obtain advice, support and guidance. All clinical staff were able to refer into this service.

Are services caring?

Summary of findings

The service was caring.

We found that patient's privacy and dignity was respected.

We were told by the Practice Manager that the practice were pro-active in identifying patients who had carers to provide them with appropriate support. Some patients had been offered 'Expert Patient' courses to help them provide effective care. Patients and their representatives were involved in consultations so that they could make an informed choice about their care.

Our findings

Respect, dignity, compassion and empathy

The practice had considered the privacy of patients whilst at reception in the design of the reception area. There was a distinct barrier in front of reception so that there was a distance between the patient at reception and other patients queuing at reception. There was also music playing in the waiting area which was intended to reduce the potential of conversations being overheard and maintain privacy at reception.

We found that all reception staff were trained to be chaperones, to provide reassurance and support to patients undergoing more intimate examinations. When clinical staff visited patients at a nearby care home they asked for a member of the residential home's staff to be present, with the patients consent. If they needed to do an examination they would ask for a female staff member for a female patient.

We found that some patients who were wheelchair users may have waited in the corridor as they did not realise that they could move the seating. We spoke with the practice manager and a GP partner regarding access to the waiting area for wheelchair users and they told us that the practice had deliberately chosen seats that could be moved to avoid isolating wheelchair users. They told us that they would make it clear to patients in future that they could move the seating if they required.

We spoke with three patients who were positive about the attitude of staff.

We found through speaking with both patients and clinicians that there were limited systems in place to identify when a patient was also a carer (aside from on the new patient registration form). Conversations with staff and patients told us that occasionally this was only identified when a carer was in crisis. Identification of carer's may help GPs to provide support to the person and consider how their clinical needs may impact on others they care for.

We found that there were systems in place for bereaved relatives to be contacted and offered support or referral to other agencies, such as, bereavement counselling. GPs were able to refer to private counselling services that were based within the practice on a weekly basis.

Are services caring?

Involvement in decisions and consent

Three patients we spoke with told us that they were consulted about their care. Where a carer was present during a consultation we found that they were encouraged to participate in the consultation, as appropriate to the situation. The patient was supported to make an informed choice about their care and treatment.

A manager from a local care home we spoke with confirmed that staff from the practice involved patients and staff, as appropriate, in the treatment process. They told us staff consulted them and discussed treatment and care. Where a decision concerning treatment needed to be made in the patient's best interest this was done appropriately.

We found that the clinical staff we spoke with had an understanding of the Mental Capacity Act 2005 (MCA). The purpose of the MCA is to empower people to make decisions wherever possible and to protect those who lack capacity by providing a flexible framework that places individuals at the heart of the decision making process.

We found that the GPs we spoke with had a robust understanding of the Gillick competency, and were able to give us examples of this in practice. The Gillick competency guidelines relate originally to a legal case around whether doctors can give contraceptive advice or treatment to under 16 year olds, but now look more generally at whether a child has the competency to make decisions and understand the implications of that decision.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive.

Patients we spoke with felt involved in their treatment and listened to.

The practice had systems in place to ensure that the most vulnerable patients had equal access to services. Consideration could be made to make available information to patients in different formats such as 'easy read' leaflets for patients with a learning disability. Where English was not the first language of a patient, translation services were accessible to support them.

The availability of appointments had been reviewed. Systems were put in place to reduce the pressure on clinical appointments by offering a range of access options, for example, with a nurse or telephone consultations.

We found that there was a complaints system in place. Complaints were responded to in a timely manner and resolved where possible to the complainant's satisfaction.

Our findings

Responding to and meeting people's needs

Patients we spoke we told us that they felt listened to and involved throughout their treatment.

The practice recognised they served a rural community and had increased the services available to patients such as a blood testing service provided Monday to Friday. Thereby, providing more accessible health services locally and reducing the need for the patient to travel to the nearest hospital which may be difficult for some patients.

We spoke with one of the GP partners who told us that when patients with learning disabilities did not attend for their appointment, either general or their annual checks, that they would be followed up to check the reason for non-attendance. The practice employed a nurse to complete home visits to a range of house bound patients including those with learning disabilities and elderly patients with restricted mobility. These patients were treated by the nurse for chronic diseases, reviews were undertaken and wounds dressed, according to their individual needs. This enabled more vulnerable group's access to services that they would not otherwise have had.

We found no practice information available in either easy read, large print or other languages for patients to read on-site. The practice website did have the ability to change the font size of information however this was not clearly sign posted on the website. This may have affected the knowledge of available services for those patients with either a sensory deficit, learning disability or those for whom English was not their first language.

The practice had met with the local authority regarding future housing development within Tiptree in order to be able to proactively look at service development and planning, to anticipate need and mitigate future risks.

Access to the service

Historically the practice had had issues with patients finding it difficult to make an appointment when they required one; this was due to the volume of patients trying to make an appointment at the same time. Patient feedback on NHS Choices from previous years reflected this. However we saw evidence that the practice had worked hard to try to resolve this. They had promoted their existing online appointment booking system to patients to try to free up the telephone system for those unable to

Are services responsive to people's needs?

(for example, to feedback?)

access the internet, and to reduce telephone waiting times to book an appointment. The practice had employed a practice nurse to run a minor ailments / express clinic Monday to Friday for one hour. The practice told us this service had been well received by patients.

Two of the four patients we spoke with told us that they had come down to the practice to book an appointment as they were unable to get through on the telephone. Two patients we spoke with had differing opinions on access via the online booking system. One person told us that the system worked well, the other person told us that unless you used it regularly it was easy to forget your password. The practice acknowledged that improving access to the service was an ongoing issue.

The practice offered surgery hours of 8:30am to 6:30pm. Seven hours of additional time were available with some early morning appointments from 6:30am and late evenings until 7:50pm to accommodate patients who worked. For a trial period Saturday appointments were also offered.

We spoke with a receptionist who told us that where patients may have physical difficulty accessing the practice, such as those mobility problems, there was a process in place for reception staff to call a nurse to assist them.

Concerns and complaints

We reviewed the systems in place for managing complaints. We saw that complaints were responded to in a timely manner and resolved where possible to the complainant's satisfaction. We could not see a complaints policy displayed in the waiting room, however there was information available on the practice's website. The practice may find it useful to note that the contact name for complaints is a member of staff who has left the practice.

The manager of a local care home for people with learning disabilities told us that they could not fault the service provided. They said that they had no concerns about the service but if they did they would know who to go to and were confident that they would be listened to and the concerns addressed.

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.

All staff were aware of their own and others roles and responsibilities within the practice. There was a clear leadership structure in place. We found that there were systems in place to monitor and improve the quality of service provision, however some of these could be developed further to be more robust. There was a commitment from all staff to learning through review and analysis of incidents.

The practice encouraged patient involvement and feedback however patients did not always engage in this process. The practice had forecast future patient needs and considered this in their contingency plans to deliver a sustainable service.

Our findings

Leadership and culture

We found that there was a clear leadership structure in place. We found through conversations with staff, including GP partners and the practice manager, that there was a commitment to quality and patient care. We found that staff had a robust understanding of how to treat patients with respect, dignity, confidentiality and equality.

Governance arrangements

Staff we spoke with had a clear understanding of their own and others roles and responsibilities. Staff received appropriate training and additional training according to their development needs. Conversations with both staff and the practice manager, and review of the practice training plan confirmed this.

We saw that there were clinical pathways in place to ensure that high quality care was delivered. These included actions to take when particular clinical staff were on leave.

Systems to monitor and improve quality and improvement

We saw that some clinical audits had been completed. However there was no structure in place to determine which audits should be done and when. Some audits were done on an ad-hoc basis in response to relevant clinical need. Follow ups from audits were not evident; therefore it was difficult to assess how the audits had contributed to patient outcomes.

We found that there was effective communication between the out of hours service and the practice. There were sound systems in place for the review and discussion of patients with palliative care needs. This level of communication and review would help to monitor and improve the quality of the service provided.

Patient experience and involvement

We spoke with representatives from the patient participation group (PPG). They told us that the group discussed feedback from patient surveys with the practice manager. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. They told us that the practice manager was available to share concerns with outside of PPG meetings and depending on the complexity of the issue these were resolved.

Are services well-led?

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

The PPG was having difficulties recruiting a cross spectrum of the practice's patient population to the forum. They had introduced virtual members who received emails and newsletter and could feedback via email any issues. The PPG representatives told us that they were trying to recruit a more diverse selection of members. The practice manager told us that they too had made attempts to engage more patients as PPG members through the website and on the new patient registration form.

The practice had also surveyed specific aspects of the service provision. For example, they had invited views on the express clinic, in order to gain patient feedback on their experiences and thoughts on the service.

A comments box and comment cards were placed, by us, in the practice for approximately two weeks prior to our inspection. We invited patients to share their experiences and thoughts on the practice with us. We raised awareness of this comments box during our inspection. We received no comments cards from patients.

We found that the practice was looking at different ways to engage patients and procure feedback. However these opportunities were not always taken up by patients.

Staff engagement and involvement

There were a variety of formal and informal meetings available for different staff groups across the practice which gave them an opportunity to share concerns, comments and seek peer support.

We found from speaking with the practice manager that staff were encouraged to share ideas for improving the service provision. We saw that one of these ideas, relating to the management of privacy at the reception desk, had been listened to and actioned.

Learning and improvement

We saw that there was learning both from significant events analysis and use of clinical audits, which drove service improvement. This learning was shared throughout the practice. For example, the reception staff received training from the lead GP partner which encouraged them to explore incidents through reflective learning.

Staff received whatever training was required both to carry out their role and to develop new roles according to their interests and the needs of the practice. Once employed staff received an induction specific to their role. Staff received annual appraisals through either an administrative lead or clinical lead according to their job role. GPs received their appraisal through a GP appraiser. This ensured that staff received appropriate support, development and monitoring to ensure that they were qualified to carry out their role.

Identification and management of risk

We found that the practice had systems in place for the identification and management of risks. For example, certain medicines prescribed require blood tests and renal function tests to check that they are not having a detrimental effect on the body. The practice found that following discharge from hospital some patients were not receiving these checks therefore they set up a system to ensure that repeat prescriptions of these medicines could not be provided unless the routine checks had been completed.

The practice had signed up to be part of a local enhanced service (LES) related to unplanned hospital admissions. The LES requires 2% of at risk adults and 2% of at risk children to have a case management strategy in place. Involvement in this service would enable the practice to develop an understanding of potential future demand on different services to be able to proactively plan for this.

Staff at the practice recognised the need for another GP at the practice to support the level of patients attending the practice. However at the time of our inspection they did not have sufficient clinical rooms to accommodate this. The practice was looking into future development of the site to enable them to employ a further GP and ensure that there was a sustainable service.

Older people

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

Summary of findings

The practice had systems in place to aid older patients to access the service. This included the practice car park and an additional one close by.

A new local enhanced service to prevent unplanned hospital admissions would mean that some patients in this population group would have their care case managed in order to reduce the likelihood of an unplanned hospital admission.

Our findings

The practice offered a service to those at greater risk of unplanned admission to hospital. The service meant that a percentage of patients, of which older people are likely to be included, will have their care case managed to ensure that any avoidable causes of hospital admission are reviewed and managed.

All patients over 75 will have a named GP at the practice who will be responsible for the coordination of their care by the practice. This process was underway at the time of our inspection.

The practice had systems in place to assist people who have reduced mobility or use mobility aids such as wheelchairs with physical access into the practice site.

During periods of heavy rain the car park was liable to flood and therefore may pose physical access problems to the care park during these times.

For housebound patients there was access to a home visiting nurse service for checks and leg dressings.

We saw that the Patient Participation Group (PPG) had two representatives that were in this age category therefore the views of older people would be sought through this. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

People with long term conditions

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

Summary of findings

There was a structure in place to ensure that patients with long-term conditions were monitored and reviewed. There was effective co-operation with other health care professionals to provide co-ordinated care.

Our findings

There was effective communication between the practice and out of hours surgery regarding patients with long term conditions.

Where a patient required palliative care services multi-disciplinary meetings were held with other health care professionals to agree and co-ordinate care.

A new service being offered meant that some of the patients in this group who were at most risk of an unplanned hospital admission would have their care case managed.

We found that the practice had lead nurses in a variety of long term conditions who were able to monitor this group of patients. We did find that for those patients with multiple long-term conditions, dependent on what they were they may need to see several nurses to monitor and review their various conditions. This was because although some nurses had dual speciality areas, most only dealt with one speciality or condition.

Patients with long-term conditions who were house bound had access to a visiting nurse from the practice who would be able to complete reviews and so on.

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

We found there were systems in place to monitor the uptake of childhood immunisations.

Smoking cessation sessions were available to pregnant women, mothers and young people.

At the time of our inspection there were no representatives from this population group on the Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

Our findings

There was a process in place for nursing staff to check the uptake of baby and child immunisations.

Baby clinics were held twice weekly at the surgery with future appointments booked following the initial attendance.

There was a smoking cessation service available to pregnant woman (and all other patients). Pregnant women were usually referred to this via the midwife.

When the Patient Participation Group (PPG) was originally set up it had two students and a mother as representatives. However currently this population group has no representatives on the PPG. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

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 reviewed its opening hours to ensure the service was accessible to those patients of working age. There was ongoing work related to access outside of normal practice hours.

This population group had the largest representation on the Patient Participation Group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

Our findings

The practice offered a morning clinic and evening clinic on different days during the week so those patients who worked could access services. There was also a trial on Saturday services designed to assist patients who worked and those who were also carers who may experience difficulties attending during the week. Surveys were being completed around patients access to services.

The Patient Participation Group (PPG) had its largest number of representatives from this population group. Although some of these members were 'virtual members' meaning they did not attend meetings.

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

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

Summary of findings

We found that the practice understood the needs of patients with learning disabilities.

The practice attracted temporary patients during harvest time as people came to work in the area. These patients had access to the full range of general medical services.

We saw that the practice had systems in place to engage vulnerable members of the Gypsy community.

Our findings

The practice provided a service to care homes providing care and accommodation for people with learning disabilities. We spoke with a manager for one of the homes who told us that the practice was excellent. They told us that the doctors and nurses from the practice have a significant understanding of people's needs and there was good communication with secondary care, for example consultants. They felt able to contact the practice at any time with concerns or comments. They told us that patients were engaged in the process were possible by clinical staff and where this was not possible appropriate action was taken.

The practice had a nurse who would complete home visits to those patients who could not access the site to complete reviews and meet their other ongoing healthcare needs.

Tiptree is a rural area and attracts temporary patients during harvest time. The practice registers the people as temporary patients during the fruit picking season.

Staff told us that they provide services to minority communities such as a Gypsy population living nearby. They told us the update of childhood immunisations was poor with this group, therefore the practice had systems in place to promote uptake of these immunisations within this community.

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

We found that the practice provided support to people experiencing poor mental health. We found through observation of staff interactions and through talking with staff that staff had a sensitive and compassionate approach to dealing with this group of patients and their relatives/carers.

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Our findings

One of the GP partners was appointed clinical lead for people experiencing poor mental health. We found that they had a clear commitment to this group of patients. When patients were identified as potentially experiencing poor mental health, they would be booked in to see this partner. The ethos of the GP partner was that where possible they would establish a therapeutic relationship with that patient and provide support themselves to ensure continuity of care. If a further referral to other mental health services was required this was completed.

The practice had counsellors available twice a week for patients, if required.

We observed during the day that the practice had a discreet and empathic approach to those patients experience poor mental health and their loved ones.