Ranworth Surgery

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

Ranworth Surgery is located in Clacton on Sea. The practice serves around 7,500 people living in the town and surrounding areas.

We found everybody benefitted from the open access surgery in the mornings, evening clinics and the ability to book appointments in advance when planning their healthcare.

The practice was responsive and effective in meeting the needs of older people. An advanced nurse practitioner visited care homes regularly to provide ongoing treatment and support.

The practice was responsive to the needs of people with long term conditions and held clinics at the practice. These included respiratory, chronic obstructive pulmonary disease (COPD), diabetes, asthma and epilepsy clinics to monitor and review long term conditions.

There were effective protocols and multi-disciplinary working arrangements in place with the local safeguarding teams to respond to the needs of the mothers, babies, children and young people.

Working age patients were kept safe as screening services were accessible to enable the early detection and treatment of health concerns.

There were processes to ensure that the practice was responsive to the needs of people in vulnerable circumstances who may have poor access to primary care. Consultations were available by telephone or by attending people's homes. The practice provided care and treatment to people who received support from a local homeless charity.

The practice was effective and responsive to the needs of people experiencing poor mental health. There were systems in place for the identification of patients with poor mental health. Annual health checks were conducted and appropriate referrals were made to specialist services, including the Child and Adolescent Mental Health team (CAHMS) and psychiatrists.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Improvements were needed to ensure the service is safe.

Patients told us that they felt safe at the practice and praised the availability of appointments and caring attitude of staff. The practice reported and responded to significant incidents. This sought to minimise the risk of such incidents to patients.

There were effective procedures in place to safeguard vulnerable adults and children.

Medicines were safely managed. The practice had procedures in place to ensure that people who had difficulty getting to the practice were able to obtain their prescriptions efficiently.

An infection control audit was conducted in May 2013 but had not been revised to address outstanding areas of non compliance. Therefore, the practice may not have identified issues that could put patients at risk of acquiring an infection. The systems, processes and practices in place to keep people safe in respect of infection control were not effective.

Are services effective?

The service was effective.

The practice provided care and treatment in line with recognised national and local guidance. The practice managed and monitored outcomes for patients with regards to reviewing medicines.

We found that the practice positively engaged and worked in partnership with other services to meet the needs of patients. Health promotion advice was provided and

Staff told us that they felt supported. They explained that they had meetings and they felt listened to as their concerns were actioned.

Are services caring?

The service was caring.

Patients felt involved in their care and treatment. They told us that doctors took the time to explain their diagnosis, using the internet to illustrate this when appropriate. We observed kind and polite discussions between patients and staff.

There was a chaperoning policy in place which staff followed to maintain patient's dignity. Appropriate arrangements were in place to obtain patient's consent.

Summary of findings

Support was given to families during bereavement. We saw that systems were in place to ensure that bereaved families were monitored and offered support by the practice.

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

The practice understood the needs of the patient population and made reasonable adjustments to meet those identified needs. Annual health checks for patients who had difficulty accessing the service were offered at the patient's own home. A practice nurse regularly attended at local care homes where patients were resident to manage their on-going health needs.

There was an open surgery for an hour each week day morning to promote effective access. Appointments could also be pre-booked. Complaints were responded to promptly and efficiently.

Are services well-led?
The service was well-led.

The practice was aware of the demographic of the practice population and there was a strategy in place to deliver high quality care and promote effective outcomes to patients.

The Patient Participation Group (PPG) had an effective and influential presence at the practice. The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided.

The practice invested in its staff who were able to progress their career within the practice if they expressed a particular interest or skill.

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

There were effective processes in place to ensure that, in the event that an older person lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached.

Representatives from care homes for older people that we spoke with told us that the practice was caring and treated patients with dignity and respect. The practice was responsive to the needs of older people.

The practice worked with a psychiatrist who specialised in the care of older people. They had regular meetings with the psychiatrist and consulted them for advice in the on-going care and treatment of older people.

People with long-term conditions

Ranworth Surgery was safe for people with long term conditions as they took a proactive approach to reviewing long-term medicines.

The practice was caring to this population group. Representatives from care homes praised the empathetic and dignified attitude of the GPs when patients were receiving end of life care.

There were effective procedures in place for people who were receiving end of life care.

The practice was responsive to the needs of people with long term conditions and held accessible clinics. These included respiratory, chronic obstructive pulmonary disease (COPD), diabetes, asthma and epilepsy clinics to monitor and review long term conditions.

Mothers, babies, children and young people

Mothers, babies, children and young people were kept safe. The practice had put in place safeguarding systems which sought to protect children from abuse.

The practice was caring towards this population group. We spoke with five mothers with young children and observed interactions with staff from the practice. Mothers were positive about the treatment they received and we observed that staff treated patients with dignity and respect.

Ranworth Surgery was responsive to the needs of mothers, babies, children and young people. The appointments system meant that they were able to attend the practice at a time that suited them.

Summary of findings

Effective multi-disciplinary working arrangements were in place with the local safeguarding teams to respond to the needs of the mothers, babies, children and young people.

The working-age population and those recently retired

Working age patients were kept safe as screening services were accessible to enable the early detection and treatment of health concerns.

The practice was caring. Working age patients told us they were involved in decisions about their care. They told us that they were asked for their consent before they received injections and that the GPs took the time to explain their diagnosis and procedures.

There was a responsive and effective service for working age patients. The practice had identified the need to provide appointments at a time which suited the working age population. This was through patient surveys and the involvement of the Patient Participation Group. Appointments were therefore available earlier in the mornings and during the early evening. This enabled patients to access the service outside of their working hours.

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

People in vulnerable circumstances who may have poor access to primary care were kept safe. The practice had put in place safeguarding systems which sought to protect vulnerable adults from abuse.

The practice was effective in meeting the needs of this population group. In the event that a patient lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with had an effective knowledge of the Mental Capacity Act.

There were administration staff who had been trained as chaperones who could accompany patients during their consultations or examinations. This maintained the dignity of vulnerable patients.

There were processes to ensure that the practice was responsive to the needs of people in vulnerable circumstances who may have poor access to primary care. For example, the practice maintained a register of people with a learning disability. A GP attended at services for people with a learning disability with a practice nurse to carry out patient's annual health checks.

Summary of findings

People experiencing poor mental health

The practice was caring, effective and responsive in meeting the needs of people experiencing poor mental health. Patients we spoke with who were, or had experienced poor mental health praised the quality of the service delivery in meeting their needs. Annual health checks were conducted and appropriate referrals were made to specialist services, including the Child and Adolescent Mental Health team (CAMHS) and psychiatrists.

Summary of findings

What people who use the service say

During our inspection we spoke with 15 patients. People we spoke with told us that they felt safe at the practice. They praised the clinical and non-clinical staff, and told us that they were able to get an appointment when they needed one. We were told that timely and appropriate referrals were made to specialist services when these were required.

The practice worked closely with the Patient Participation Group (PPG) to obtain the feedback of people who used the service and acted in response to feedback obtained. Patients were aware of the PPG and what its function was. One patient told us that they had been invited to attend the PPG meetings but were unable to attend due to on-going commitments. They told us that they continued to receive the minutes of the meetings.

We received and reviewed 30 comments cards which had been left by us for patients to complete by the CQC prior to our inspection. 24 of these were very positive, praising the availability of appointments and the caring attitude of the doctors and clinical staff. Three patients raised concerns about the practice being busy during open practice. The other three concerns raised did not identify any common themes.

Areas for improvement

Action the service MUST take to improve

- The practice must revised their infection control audit from 2013 and risk assessment to ensure that patients are protected against the risk of acquiring an infection during their visit to the practice.

Action the service COULD take to improve

- The practice could take steps to ensure prescription stationery stock is received and distributed as required under the NHS Protect guidance, August 2013.
- The practice could ensure records of pre-employment checks for staff were maintained.
- The practice may consider a definitive appointment within the staff team of a Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.
- The practice could revisit action plans which had been put in place after a significant event to ensure that these had been successfully implemented.

Ranworth Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a lead inspector and a GP. A practice manager, a second inspector and an expert by experience also attended the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses primary medical care services.

Background to Ranworth Surgery

Ranworth Surgery provides primary medical services to approximately 7,500 people living in Clacton-on-Sea and surrounding areas. Surgery by appointment begins at 8:30am and there is an open surgery at 10:30am until 11:30am for people who do not have an appointment. Telephone consultations are available for people who do not wish to attend open surgery.

There were three GP partners at the practice and one partner who was a nurse practitioner. The nurse practitioner was also the registered manager with the Care Quality Commission. One of the partners had retired and the practice was in the process of notifying us of this. There were two further nurse practitioners one of whom provided support for patients in the community. All of the nurse practitioners were trained to prescribe medicines to patients.

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

We carried out an announced inspection of Ranworth Surgery on 4 June 2014. During our visit, we spoke with a range of staff including the practice manager, registered manager, GP partners, a healthcare assistant, as well as reception and administration staff. We spoke with patients who were visiting the practice and observed how staff interacted with them. We spoke with carers and/or family members. We looked at documentation, for example policies, procedures and audits that had been provided by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about Ranworth Surgery. We spoke with care homes in the area that used the practice and to two members of the patient participation group.

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?

Detailed findings

- 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

Are services safe?

Summary of findings

Improvements were needed to ensure the service is safe.

Patients told us that they felt safe at the practice and praised the availability of appointments and caring attitude of staff. The practice reported and responded to significant incidents. This sought to minimise the risk of such incidents to patients.

There were effective procedures in place to safeguard vulnerable adults and children.

Medicines were safely managed. The practice had procedures in place to ensure that people who had difficulty getting to the practice were able to obtain their prescriptions efficiently.

An infection control audit was conducted in May 2013 but had not been revised to address outstanding areas of non compliance. Therefore, the practice may not have identified issues that could put patients at risk of acquiring an infection. The systems, processes and practices in place to keep people safe in respect of infection control were not effective.

Our findings

Safe patient care

During our inspection we spoke with 15 patients, who told us that they felt safe at the practice. We obtained feedback from representatives from care homes where residents were patients of the practice. One representative explained how the practice nurse had effectively responded to an emergency situation earlier in the day of our telephone conversation by involving the GP and subsequently calling an ambulance.

Learning from incidents

We found that the practice recorded significant incidents and staff were able to explain the mechanisms in place to deal with these. We saw that an action plan was completed after the event, although this was not revisited again to ascertain whether the action plan had been successful. There was some evidence of the significant events being discussed at meetings. We saw from meeting minutes that not all relevant staff necessarily attended the meetings in which the significant event was discussed and therefore may not have benefitted from shared learning.

Safeguarding

The practice had arrangements in place to ensure that patients were safeguarded against the risks of abuse. We saw evidence which confirmed that staff had received training about protecting children and vulnerable adults from abuse. Staff were knowledgeable about the procedures that were in place, and gave examples of where safeguarding concerns had been raised.

Although there was no written safeguarding policy, there were effective procedures and a nominated safeguarding lead appointed to ensure that effective procedures were followed. There was a shared electronic library of resources so that staff could access relevant contacts in the event that they needed to raise an alert.

The practice worked in partnership with social services to share any information of concern. We saw that the safeguarding lead closely monitored and reviewed on-going concerns, which was supported through information and alerts on the shared computer systems.

Are services safe?

Monitoring safety and responding to risk

Alerts that needed to be bought to the clinician's attention were recorded in patients' medical records, such as whether a child patient was the subject of a social service's investigation or if a patient was receiving end of life care.

A named member of the administration team was tasked with summarising patient's records. This was checked by clinical staff when they accessed the system and audited by the registered manager, who was also had a clinical role within the service. This sought to ensure that people's records were an accurate and informed clinical record. We noted that read codes, the clinical encoding of people's medical history and background, were also checked and audited to ensure that clinicians were aware of people's health needs.

A member of administrative staff was responsible for sending prescribing alerts electronically to clinicians who would acknowledge that they had received them. Prescribing alerts inform clinicians when there is an immediate concern with a medicine. When alerts were received from the police regarding people believed to be trying to gain unauthorised access to medicines, this was shared with reception staff to ensure that suitable arrangements were in place to mitigate the risk of medicines being accessed. We spoke with reception staff who confirmed the details of the last alert which confirmed what we had been told by the practice manager.

The emergency medicines kit, which would be used in the event that a patient or person at the practice needed emergency first aid or treatment was regularly checked, in date and stored appropriately.

Medicines management

Repeat prescriptions could be ordered either at the practice or online. People we spoke with told us that their medicines were explained to them, including how to take them and any possible side effects, therefore assisting patients to manage their medication safely.

The practice had procedures in place to ensure that people who had difficulty getting to the practice were able to obtain their prescriptions efficiently; for example we were informed by a representative from a care home that a GP would regularly attend the home to go through each patient's repeat prescription to ensure that these were generated effectively.

The temperatures of the fridge used to store medicines had not been recorded in the month of January 2014. Fridge temperatures need to be checked consistently to ensure the correct temperature is maintained to preserve the integrity of the medicines that are stored in them. We raised this with the registered manager who explained that this was because she was on a period of leave and no other staff member had checked the temperatures. Following this incident we saw that the fridge protocol had been immediately updated to state that the fridge temperature should be checked by the first nurse to arrive into the practice. We saw that thereafter, the temperatures were checked regularly.

We found that an out of date bottle of foetal doppler ultrasound gel was in use. It had expired in 2005. This was brought to the attention of the registered manager who immediately disposed of the item. We found that the expiry dates of other medicines were monitored on monthly basis using an electronic system. The registered manager advised us that although these were also checked manually, there was no record maintained of this.

On reviewing the management of prescription pads, we found that a box of the paper was unaccounted for. Therefore, the stock was not securely stored as required under the NHS Protect guidance, August 2013. We were informed after the inspection that the most of the prescription paper had been located in printer trays in clinicians' rooms.

Cleanliness and infection control

We found that clinical areas and communal areas were visibly clean although we noted that there was not coved flooring on one side of the treatment room where minor surgery was conducted. This presented an infection control risk as it was difficult to clean effectively.

Staff had completed training on infection control. We saw that there was a cleaning protocol which detailed the clinical equipment to be cleaned and whether this was to be cleaned daily or monthly. There was also a cleaning plan in place which detailed the areas in the practice to be cleaned and how often. However, there was no checklist in place to identify when or if all areas had been cleaned. Therefore, the practice were unable to assure themselves that cleaning tasks that they had identified as being necessary had been completed.

Are services safe?

There was not an effective operation of systems in place to assess the risk of and prevent, detect and control the spread of infection. An infection control audit had been conducted in May 2013 but had not been revised to address outstanding areas of non- compliance. There was an infection prevention control lead appointed, but they were not aware of the Department of Health's code of practice on the prevention and control of infections. Therefore, the practice may not have identified issues that could put patients at risk of acquiring an infection.

Staffing and recruitment

There were systems in place to cover for expected and unexpected absences. In the event that reception staff were on holiday or unable to attend work, there were other members of administrative staff who could work in reception. The nurses had opposing days off and so would provide cover if the other was absent. Staff that we spoke with said that there were a sufficient number of staff on duty to meet the needs of the practice population.

We looked at four staff files. Whilst all of these evidenced that Criminal Records Bureau (CRB) or Disclosure and Barring Service (DBS) checks had been undertaken, we could not see evidence of other pre-employment checks, for example references. We were informed by the practice manager that all administration staff were issued with a smartcard to access the patient systems, and that thorough checks of the applicant's suitability were undertaken by the Clinical Commissioning Group before these were issued.

Dealing with Emergencies

We were shown a business continuity plan that considered potential emergency situations and suitable measures to mitigate the risks to the running of the service. It was apparent that this was a generic document that had not been amended to reflect the needs of the practice.

A fire risk assessment had been undertaken by an external contractor in March 2014. We saw that various actions were detailed, such as fire marshal training. Also, the assessment had identified that appropriate signage needed to be displayed next to where the oxygen had been stored as it presented a potential fire hazard. However, we found that actions had not completed within the given timeframes and were still outstanding such as ensuring appropriate signage for the storage of the oxygen cylinder.

Equipment

There were systems in place with regards to the use and maintenance of the equipment and premises to ensure that people were safe. The servicing and calibration of equipment, including clinical equipment, was completed in a timely manner. Portable Appliance Testing had been completed prior to our inspection.

There were effective protocols in place to support the use of the emergency equipment. There were adequate supplies of emergency equipment available.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective.

The practice provided care and treatment in line with recognised national and local guidance. The practice managed and monitored outcomes for patients with regards to reviewing medicines.

We found that the practice positively engaged and worked in partnership with other services to meet the needs of patients. Health promotion advice was provided and

Staff told us that they felt supported. They explained that they had meetings and they felt listened to as their concerns were actioned.

Our findings

Promoting best practice

The practice provided care and treatment in line with recognised national and local guidance. This was evidenced by statistical data that we reviewed during the course of the inspection. The practice offered various enhanced services. Some primary medical services are commissioned by the local Clinical Commission Group (CCG) to provide enhanced services in order to meet local need, improve convenience and extend choice to the practice population. A GP at the practice was a GPwSI (General Practitioner with Special Interest) in headache and held specialist clinics at the practice every other week. This service could be accessed by means of referral from the practice or from other primary medical care services.

Management, monitoring and improving outcomes for people

Prior to our inspection, we obtained data which identified that the practice had a higher level of prescribing hypnotics. These are medicines that are used to treat problems with insomnia. It was identified during the course of the inspection that this was due to the high prevalence of depression and alcohol dependency which was also contributed to by the patient age profiles within the practice population. We also acknowledged with the practice issues with high prescribing of antibiotics. This was also identified by the practice to be due to the demographic of the practice population.

A patient we spoke with explained that the doctor had taken them off their medication as they had been taking his for some time. They told us that they were now looking at alternative medication. This demonstrated that the practice took a proactive approach to reviewing the patients on long-term medicines.

The practice manager explained that they were recruiting a prescriptions clerk into the practice. This was also evidenced in meeting minutes. We were informed that the role of the prescriptions clerk would be to administer prescriptions but also to audit and monitor repeat medicines to enable the practice to effectively review patients' on-going medication needs.

Are services effective?

(for example, treatment is effective)

The practice was identified as having lower rates than average of detecting diabetes. We found the practice adopted a proactive approach to diabetes monitoring through holding regular clinics and promoting staff awareness.

The practice performed well across all other national indicators used to monitor the quality of the services, including cervical screening.

Staffing

The GPs at Ranworth Surgery were subject to external peer review with five other practices in the area to ensure that the care and treatment that they delivered was in line with recognised guidance and standards.

The practice was in the process of becoming registered as a training practice. This is where qualified doctors, referred to as registrars, could be supported and trained to become GPs. We saw that a room had been set aside for the training of such staff and that a library was being developed to support ongoing learning requirements. A GP trainer had been identified.

We found three out of the four files reviewed did not include a current appraisal conducted within the last year. The three files without appraisals related to nursing staff. We were informed that appraisals for nursing staff were carried out by the registered manager who was also the nursing lead. They advised us that they were in the process of completing the appraisals, although it was apparent that these had lapsed. We saw that some nursing staff had been asked to complete a pre-appraisal form and update their job descriptions in anticipation of their forthcoming appraisal.

Staff told us that there was an open door policy at the practice. They said that they felt confident in approaching the practice manager. They explained that they had meetings and they felt listened to as their concerns were actioned.

Working with other services

We found that the practice positively engaged and worked in partnership with other services to meet the needs of patients. Palliative care meetings, involving a MacMillan nurse took place once a month to promote effective joined up working in the community. The practice appointed a nurse practitioner who conducted home visits and visits to care homes. This nurse practitioner attended the palliative care meetings to ensure that the experiences of patients who could not access the practice were discussed. We spoke with a member of the administration team who explained that they are looking to develop these meetings to also focus on admission avoidance. Admission avoidance aims for patients to receive appropriate care and treatment from their GP as opposed to needing to attend hospital services.

Health, promotion and prevention

Representatives from care homes we spoke with in the area confirmed that they had a good working relationship with the practice. They told us that the nurse practitioner attended the services to complete people's yearly reviews to check their general health and review their medication. We were informed that the nurse practitioner maintained communication with the GPs during the visits as necessary to ensure that appropriate and timely treatment was provided.

Evidence demonstrated that the service had a good uptake of females partaking in the cervical screening programme. Female patients that we spoke with confirmed that they were able to get an appointment with a female GP should they request this.

A range of clinics were available to meet the health needs of the practice population. These included a diabetes Clinic, over 40s regular health checks, smoking cessation advice, coronary heart disease and a Chronic Obstructive Pulmonary Disease (COPD) clinic. A link to the Change for Life website was available on the practice's website. This provided information about how people could maintain their own health by making changes to their lifestyle.

The Tendring Area Health profile identified that Tendring is worse than the national average in reducing the number of women smoking in pregnancy. To address this issue, the practice delivered smoking cessation advice and support through a general nursing clinic.

Are services caring?

Summary of findings

The service was caring.

Patients felt involved in their care and treatment. They told us that doctors took the time to explain their diagnosis, using the internet to illustrate this when appropriate. We observed kind and polite discussions between patients and staff.

There was a chaperoning policy in place which staff followed to maintain patient's dignity. Appropriate arrangements were in place to obtain patient's consent.

Support was given to families during bereavement. We saw that systems were in place to ensure that bereaved families were monitored and offered support by the practice.

Our findings

Respect, dignity, compassion and empathy

We observed kind and polite discussions between patients and staff. The reception desk was situated in the waiting area. The seating was positioned to focus on the television rather than the reception desk so that confidentiality could be maintained when patients needed to have discussions with the reception staff. Patients told us that reception staff spoke quietly and discreetly on the telephone which sought to ensure that confidential discussions could not be overheard.

We noted that the GPs and other clinical staff personally attended the waiting areas to call patients for their appointments. We observed friendly and polite exchanges between the clinical staff and the patients.

There was a chaperoning policy in place which staff followed to maintain patients' dignity. Information about the availability of chaperones was displayed in the communal areas and on the practice's internet page. Chaperones had received training and had been subject to appropriate checks to ensure they were suitable to undertake this role.

Involvement in decisions and consent

Patients told us that they felt involved in their care and treatment. They told us that GPs took the time to explain their diagnosis, using the internet to illustrate this when appropriate.

We spoke with two GPs and a nurse practitioner about their knowledge of The Children Act 1989, Mental Capacity Act 2005 and how they ensured they obtained informed consent from patients. All were knowledgeable and confident applying the principles of this legislation.

We obtained feedback from representatives from care homes where residents were patients of the practice. They told us that the practice nurse involved patients' relatives/carers and worked in the best interests of patients when a patient did not have mental capacity to make a decision.

Patient consent was obtained prior to minor surgery. Patients told us that the GPs regularly ask them about whether they consent to a course of treatment.

Bereavement

Representatives from care homes were very positive about the role of the visiting practice nurse when difficult

Are services caring?

discussions needed to be had with families about end of life decisions. They explained that the visiting practice nurse would sensitively complete necessary formalities with the patient's families. Representatives also praised the empathetic and dignified attitude of the GPs.

We saw that systems were in place to ensure that bereaved families were monitored and offered support. The computer systems were updated when a person passed away to ensure that the practice was sensitive to their loss.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs.

The practice understood the needs of the patient population and made reasonable adjustments to meet those identified needs. Annual health checks for patients who had difficulty accessing the service were offered at the patient's own home. A practice nurse regularly attended at local care homes where patients were resident to manage their on-going health needs.

There was an open surgery for an hour each week day morning to promote effective access. Appointments could also be pre-booked. Complaints were responded to promptly and efficiently.

Our findings

Responding to and meeting people's needs

The practice understood the needs of the patient population and made reasonable adjustments to meet those identified needs. The practice was accessible to patients in vulnerable circumstances who may have had poor access to primary care. The practice maintained a register of patients with mental health problems and also patients who had a learning disability; annual health checks were completed either at the practice or in the patient's own home. The practice was also accessible to patients who were referred through a local organisation for people who were homeless.

We spoke with representatives of three care homes that the practice visited. All were very positive about Ranworth Surgery. One representative explained that the practice was proactive in completing health checks and that they never needed reminding. They told us that the visiting practice nurse was on first name terms with the staff and that there was a good working arrangement in place. Another representative explained that historically there had been problems with repeat prescriptions, although this had been resolved as a GP attended the home regularly to ensure that prescriptions were generated effectively.

The practice worked with a psychiatrist who specialised in care for older people. They had regular meetings with the psychiatrist and consulted him for advice regarding the on-going care and treatment of older people.

Patients we spoke with said that they were referred to specialist services promptly. The practice used the 'choose and book' service to ensure that emergency referrals were made efficiently.

Access to the service

We reviewed minutes of a Patient Participation Group (PPG) meeting whereby the issue of patients not attending their appointments was discussed. The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided. The practice manager had conducted a survey into why patients missed their appointments. It was found that in most cases, patients had forgotten their appointment. The PPG thereafter conducted a further survey which found that a vast majority of people who used the survey would be happy to receive a reminder of their appointment by

Are services responsive to people's needs?

(for example, to feedback?)

text message. This system was in place on the day of our inspection. This demonstrated that the practice responded appropriately to the views of patients to promote efficient access to the service.

In response to increased waiting times for appointments, the practice had an open surgery between 10.30am to 11.30am where patients were guaranteed to be seen. This allowed the practice to create an additional 70 routine appointments a week. Whereas a majority of patients praised the new system and accessibility, some raised concerns about how busy the open surgery was.

Information about the treatment and diagnosis given at the out of hours' appointment was received into the practice promptly after people had accessed these services. This information was reviewed by the nurse practitioners who would alert the person's GP if they found information of concern. This was intended to ensure that relevant information was shared so that people experienced a consistent delivery of care.

Concerns and complaints

We saw that four written complaints were received last year. These raised concerns about the access to appointments and prescriptions. We saw that these were responded to in a timely fashion. Three were responded to within a week in accordance with the complaints policy.

There was information about the complaints policy available on the practice's website. Patients we spoke with were aware that they could speak with the practice manager about their concerns.

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.

The practice was aware of the demographic of the practice population and there was a strategy in place to deliver high quality care and promote effective outcomes to patients.

The Patient Participation Group had an effective and influential presence at the practice. The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided.

The practice invested in its staff who were able to progress their career within the practice if they expressed a particular interest or skill.

Our findings

Leadership and culture

The practice was aware of the demographic of the practice population and there was a strategy in place to deliver high quality care and promote effective outcomes to patients. The practice manager gave us a detailed insight into the practice population prior to our inspection. During our inspection, we found that the practice had clinics and systems in place to meet those identified needs.

Data showed that life expectancy in the Tendring district is 8.8 years lower for men and 6.3 years lower for women. Tendring district is the 81st most deprived out of 326 local authorities. There are approximately 6,200 children living in poverty, which is worse than the England average. Data identified that the priorities in the Tendring district included reducing levels of obesity, improving the outcomes of people with long term conditions and improving mental health outcomes. These priorities were being addressed by the practice through the specialist and general nursing clinics provided and joint working with other providers.

The practice manager explained the on-going changes and developments within the organisation to meet the needs of the increasing practice population. They made reference to enhanced services and clinics available at the practice. Some primary medical services are commissioned by the local Clinical Commission Group (CCG) to provide enhanced services in order to meet local need, improve convenience and extend choice to the practice population. There was an advanced nurse practitioner appointed to conduct visits to care homes and in people's homes which encapsulated the proactive admission avoidance ethos. Further, the services were accessible to people who were homeless and systems had been put in place to manage this. Effective systems were in place to monitor children who were considered to be at risk of abuse. This demonstrated an awareness of the needs of the practice demographic.

Governance arrangements

The registered manager was appointed as clinical lead in numerous roles. Whilst evidence and feedback demonstrated an effective leadership presence, there were instances whereby the lack of a devolved management structure had had a negative impact on outcomes. For instance, this included an increase in diabetes admissions

Are services well-led?

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

which the registered manager said may have related to their absence and lack of action with regards to taking fridge temperatures during the absence of the registered manager.

We reviewed a significant event which involved the disclosure of confidential information. At the date of our inspection, it was apparent that appropriate action had not been taken to inform all relevant parties. We drew this to the attention of the provider who had since confirmed that appropriate action has subsequently been taken. It was unclear who was appointed as Caldicott Guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian by the Health Service Circular: HSC 1999/012. The partner who previously had responsibility for this had retired from the practice.

Systems to monitor and improve quality and improvement

The registered manager had conducted some clinical audits with regards to diabetic medication and another with a view to changing clinical supplies. However, it was unclear what systems were in place with regards to on-going monitoring and improvement in terms of an on-going audit cycle.

We found that the partnership had regular meetings with the management team to agree significant decisions. A shutdown meeting involving all staff took place twice a year in which significant incidents and complaints were scheduled to be discussed. Minutes showed that it was identified in June 2013 that a significant event protocol needed to be designed and we found that significant events were being reported.

Patient experience and involvement

There was an active patient participation group (PPG) that met quarterly. The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided. There was information on how to join the PPG on the practice's webpage. Patients that we spoke with told us that the PPG had an effective presence at the practice, asking patients to complete feedback forms and inviting patients to attend meetings.

An annual report prepared by the PPG was available on the practice website. We saw evidence to show that the practice was responsive to the issues found by the PPG.

Staff engagement and involvement

It was evident that Ranworth Surgery invested in its staff. Reception staff had been trained as phlebotomists where they had expressed an interest. Further, reception staff had been placed into specialist administrative roles where relevant skills had been identified.

We saw that reception meetings were scheduled to take place monthly, although this was not always the case due to staff commitments. Staff that we spoke with told us that they felt listened to by the provider and that action was taken in response to the comments raised.

Learning and improvement

The practice was able to provide electronic evidence of using approved data to improve the quality of services. This included using emergency admission data to ensure high level and consistent clinical input to people who lived in care home, led by an advanced nurse practitioner.

Identification and management of risk

We saw a complaint which involved a significant delay in receiving a repeat prescription for important medication. We found that following the identification of the risks to generating repeat prescriptions that changes were made to the prescription process. The practice was in the process of appointing a prescriptions clerk to oversee repeat medicines. The practice was also changing to electronic prescriptions in the weeks following our inspection.

The Electronic Prescriptions Service sends prescriptions electronically to pharmacies for collection, avoiding lost prescriptions and is intended to improve efficiency. This demonstrated that the provider had considered the risk highlighted in the complaint and reviewed systems as a result.

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

There were effective processes in place to ensure that, in the event that an older person lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached.

Representatives from care homes for older people that we spoke with told us that the practice was caring and treated patients with dignity and respect. The practice was responsive to the needs of older people.

The practice worked with a psychiatrist who specialised in the care of older people. They had regular meetings with the psychiatrist and consulted them for advice in the on-going care and treatment of older people.

Our findings

There were effective processes to ensure that, in the event that an older person lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with had an effective knowledge of the Mental Capacity Act.

The practice was responsive to the needs of older people. Patients in care homes were able to access services in a timely way as an advanced nurse practitioner visited regularly. The nurse practitioner completed patients' yearly reviews to check their general health and medication. We were informed that the visiting nurse practitioner maintained communication with the GPs during the visits as necessary to ensure that appropriate and timely treatment was provided. They told us that the practice was caring and treated patients with dignity and respect.

The practice worked with a psychiatrist who specialised in the care of older people. They had regular meetings with the psychiatrist and consulted him for advice regarding the on-going care and treatment of older people.

The practice worked with the local care advisor, who provided advice, support, information and assistance to vulnerable people in their own homes on subjects such as welfare benefits, access to social care and support to maintain their independence.

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

Ranworth Surgery was safe for people with long term conditions as they took a proactive approach to reviewing long-term medicines.

The practice was caring to this population group. Representatives from care homes praised the empathetic and dignified attitude of the GPs when patients were receiving end of life care.

There were effective procedures in place for people who were receiving end of life care.

The practice was responsive to the needs of people with long term conditions and held accessible clinics. These included respiratory, chronic obstructive pulmonary disease (COPD), diabetes, asthma and epilepsy clinics to monitor and review long term conditions.

Our findings

Ranworth Surgery was safe for people with long term conditions. Although data identified that the practice had a higher rate than average of prescribing antibiotics, the practice demonstrated that they took a proactive approach to reviewing long-term medicines. A prescriptions clerk was being recruited into the practice who would oversee repeat medicines to enable effective reviews of patients' on-going medication needs.

The practice was caring in its approach. Representatives from care homes were very positive about the role of the visiting practice nurse when difficult discussions needed to be had with families about end of life decisions. They explained that visiting practice nurse would sensitively complete necessary formalities with the patient's families. Representatives also praised the empathetic and dignified attitude of the GPs.

There were effective procedures in place for people who were receiving palliative care. Palliative care is care given to relieve the pain, symptoms and stress to terminally ill patients. Multi-agency palliative care meetings were held monthly. These meetings were attended by community matrons, MacMillan nurses and the nurse practitioner who worked in the community and the lead GP responsible for end of life care.

The practice was responsive to the needs of people with long term conditions and held accessible clinics. These included respiratory, Chronic Obstructive Pulmonary Disease (COPD), diabetes, asthma and epilepsy clinics to monitor and review long term conditions.

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

Mothers, babies, children and young people were kept safe. The practice had put in place safeguarding systems which sought to protect children from abuse.

The practice was caring towards this population group. We spoke with five mothers with young children and observed interactions with staff from the practice. Mothers were positive about the treatment they received and we observed that staff treated patients with dignity and respect.

Ranworth Surgery was responsive to the needs of mothers, babies, children and young people. The appointments system meant that they were able to attend the practice at a time that suited them.

Effective multi-disciplinary working arrangements were in place with the local safeguarding teams to respond to the needs of the mothers, babies, children and young people.

Our findings

The practice had put in place safeguarding systems which sought to protect children from harm. Staff had received training in safeguarding children and demonstrated a good knowledge of what they would do if they suspected a child was at risk of abuse. There were policies in place for safeguarding children. Disclosure and Barring Service checks had been undertaken before staff began to work at the practice to ensure staff were suitable to work with children.

The practice was caring towards mothers, babies, children and young people. We spoke with five mothers with young children and observed interactions with staff from the practice. Mothers were positive about the treatment they received and we observed that staff treated patients with dignity and respect.

Ranworth Surgery was responsive to the needs of mothers, babies, children and young people. The appointments system meant that they were able to attend the practice at a time that suited them. One parent told us that reception staff would make appointments available after school so that children's education could be maintained whilst they met their health needs.

Tendring District is the 81st most deprived out of 326 local authorities. There are approximately 6,200 children living in poverty, which is worse than the England average. The safeguarding lead demonstrated effective multi-disciplinary working with the local safeguarding teams to respond to the needs of the mothers, babies, children and young people. We saw how information was shared when it was suspected that a child was a victim of abuse. There were effective systems in place to identify children who were at risk, both by electronic means and local knowledge and understanding.

Mothers, babies, children and young people

The Tendring Area Health profile identified that Tendring is worse than the national average in reducing the number of women smoking in pregnancy. To address this issue, the practice delivered smoking cessation advice and support through a general nursing clinic.

Two GPs at the practice offered weekly ante-natal and post natal clinics every week. Six to eight week baby check appointments were also booked into this clinic. Meeting minutes showed that systems were in place to ensure that all babies were registered with a GP and that they had received their checks and immunisations.

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

Working age patients were kept safe as screening services were accessible to enable the early detection and treatment of health concerns.

The practice was caring. Working age patients told us they were involved in decisions about their care. They told us that they were asked for their consent before they received injections and that the GPs took the time to explain their diagnosis and procedures.

There was a responsive and effective service for working age patients. The practice had identified the need to provide appointments at a time which suited the working age population. This was through patient surveys and the involvement of the Patient Participation Group. Appointments were therefore available earlier in the mornings and during the early evening. This enabled patients to access the service outside of their working hours.

Our findings

Working age patients were kept safe. Patients aged 40 years and above were offered a NHS health check which checked patients' circulatory and vascular health. Women were offered routine cervical screening. This meant that patients were provided with screening services to enable the early detection and treatment of health concerns.

Working age patients told us they were involved in decisions about their care. They told us that they were asked for their consent before they received injections and that the GPs took the time to explain their diagnosis and procedures.

There was a responsive and effective service for working age patients. Through patient surveys and the involvement of the PPG, the provider proactively identified the need to provide appointments that met the needs of working aged patients. Appointments were available earlier in the mornings and early in the evening to make appointments more accessible to working age patients. This included cervical smears. Appointments could be booked online the evening before the consultation was required which sought to ensure that patients could achieve and maintain good health whilst they fulfilled their employment obligations. Reminders of the appointment were sent to patients' by text message to ensure that appointments' systems were effectively managed.

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

People in vulnerable circumstances who may have poor access to primary care were kept safe. The practice had put in place safeguarding systems which sought to protect vulnerable adults from abuse.

The practice was effective in meeting the needs of this population group. In the event that a patient lacked mental capacity, the clinician involved patients' relatives and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with had an effective knowledge of the Mental Capacity Act.

There were administration staff who had been trained as chaperones who could accompany patients during their consultations or examinations. This maintained the dignity of vulnerable patients.

There were processes to ensure that the practice was responsive to the needs of people in vulnerable circumstances who may have poor access to primary care. For example, the practice maintained a register of people with a learning disability. A GP attended at services for people with a learning disability with a practice nurse to carry out patient's annual health checks.

Our findings

The practice had put in place safeguarding systems which sought to protect vulnerable adults from abuse. Staff had received training about protecting vulnerable adults from abuse and were knowledgeable about the procedures that were in place.

The practice was effective in meeting the needs of this population group. In the event that a patient lacked mental capacity, the clinician involved patients' relatives/carers and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with had an effective knowledge of the Mental Capacity Act.

There were trained chaperones at the practice who could accompany patients during their consultations or examinations to maintain the dignity of vulnerable patients. Information about the availability of chaperones was displayed in the communal areas and on the practice's internet page. Chaperones had received appropriate checks to ensure they were suitable to undertake this role.

There were processes to ensure that the practice was responsive to the needs of people in vulnerable circumstances who may have poor access to primary care. The practice provided care and treatment to people who were homeless and receiving support from a local organisation.

The practice maintained a register of people with a learning disability to ensure that their health needs were reviewed and met. A GP attended at services for people with a learning disability with a practice nurse to carry out patient's annual health checks. They discussed the need for cervical screening with them and carers were also involved, where appropriate.

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 was caring, effective and responsive in meeting the needs of people experiencing poor mental health. Patients we spoke with who were, or had experienced poor mental health praised the quality of the service delivery in meeting their needs. Annual health checks were conducted and appropriate referrals were made to specialist services, including the Child and Adolescent Mental Health team (CAHMS) and psychiatrists.

Our findings

Patients that we spoke with who were, or had experienced poor mental health praised the quality of the service delivery in meeting their needs. In the event that a patient lacked mental capacity, the clinician involved patients' relatives/carers and worked in the patients' best interests to enable a decision to be reached. Clinicians that we spoke with had an effective knowledge of the Mental Capacity Act.

The practice was effective and responsive to the needs of people experiencing poor mental health. There were systems in place for the identification of patients with poor mental health. Annual health checks were conducted and appropriate referrals were made to specialist services, including the Child and Adolescent Mental Health team (CAHMS) and psychiatrists.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	The systems, processes and practices in place to keep people safe in respect of infection control were not effective. We have identified this as a breach of Regulations 12 (2)(a) & 12 (2)(c)(i).

Regulated activity	Regulation
Family planning services	The systems, processes and practices in place to keep people safe in respect of infection control were not effective. We have identified this as a breach of Regulations 12 (2)(a) & 12 (2)(c)(i).

Regulated activity	Regulation
Maternity and midwifery services	The systems, processes and practices in place to keep people safe in respect of infection control were not effective. We have identified this as a breach of Regulations 12 (2)(a) & 12 (2)(c)(i).

Regulated activity	Regulation
Surgical procedures	The systems, processes and practices in place to keep people safe in respect of infection control were not effective. We have identified this as a breach of Regulations 12 (2)(a) & 12 (2)(c)(i).

Regulated activity	Regulation
Treatment of disease, disorder or injury	The systems, processes and practices in place to keep people safe in respect of infection control were not effective. We have identified this as a breach of Regulations 12 (2)(a) & 12 (2)(c)(i).