Ramsey Health Centre

Quality Report

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

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Summary of findings

Overall summary

Ramsey Health Centre provides a range of primary medical services to approximately 7,000 people.

During our inspection we spoke with 15 patients and with a representative of the practice's patient participation group (PPG). A PPG represent patients' views and works in partnership with the practice with a broad aim of ensuring the practice puts the patient, and improving health, at the heart of everything it does. We spoke with eight members of staff including three GPs and two nurses and two practice managers. We looked at procedures and systems and considered whether the practice was safe, effective, caring, responsive and well led. All of the patients that we spoke with were very complimentary about the service. They told us that they were treated with respect and they were satisfied with the care and treatment they received. We saw results of patient surveys carried out by the practice which showed that patients were pleased with the service and that the practice had responded to their views and complaints.

We met with and listened to the views expressed by several support organisations for vulnerable people at a public listening event. We consulted with the Clinical Commissioning Group (CCG) the NHS Local Area Team and with Local Health Watch.

We examined patient care across six population groups: older people, people with long term medical conditions, mothers, babies, children and young people, working age people and those recently retired, people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health. We found that care was appropriate to the individual circumstances and needs of patients in these groups.

Ramsey Health Centre had procedures in place for reporting and recording incidents and analysing significant events. They had suitable policies and procedures in place to safeguard vulnerable adults and children. We found that improvement was required for the management of medicines.

The practice had procedures in place to deliver care and treatment to patients in line with the appropriate standards. We saw evidence of effective working with other members of a multidisciplinary team.

The practice was responsive to patients' needs. Patients were given the opportunity to give their views and the practice demonstrated they listened to and responded to their patient participation group.

The provider was in breach of regulations related to the management of medicines. We found that some of the repeat prescription forms for medication had not been signed by a GP prior to these prescription forms being given to patients.

Please note that any references to the Quality and Outcomes Framework data in this report, relates to the most recent information available to the CQC at that time.

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 services at Ramsey Health Centre were in need of improvement to ensure they are safe. Improvement is required because the practice was in breach of regulations relating to the safety and management of medicines when we found that some repeat prescription forms had not been signed by a GP. All other areas of this domain were safe.

Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

The services at Ramsey health Centre were effective. There were systems in place to ensure that treatment was delivered in line with best practice standards and guidelines. The practice had carried out audits of its activities. There was evidence of multi-disciplinary working. The practice had ensured they were able to provide sufficient appointments to meet patient demand. The practice was an approved GP training practice and offered placements to GP registrars.

Are services caring?

The practice was caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We observed that staff treated patients with kindness and respect and ensured that confidentiality was maintained.

Are services responsive to people's needs?

The practice was responsive to patients' needs. We found the practice had initiated positive service improvements for their patients. The practice had implemented suggestions for improvements and made changes to the way it provided appointments as a consequence of feedback from a survey and from the Patient Participation Group (PPG).

Summary of findings

Patients reported good access to a GP of their choice at the practice or, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

There was an accessible complaints system and we saw evidence to demonstrate that the practice responded quickly to issues raised. There was evidence of shared learning amongst staff and other stakeholders.

The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were required.

Are services well-led?

The practice was well-led. The practice had a vision and there was a strategy in place to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting took place.

There were systems in place to monitor and improve quality and to identify risks. The practice had proactively sought feedback from staff and patients and this had been acted upon. The practice had an established and active patient participation group (PPG).

Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long-term conditions

The practice had dedicated clinics for long term conditions such as diabetes, chronic obstructive pulmonary disease and patients taking anticoagulation drugs. When needed, longer appointments and home visits were available.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP and nurses worked with relevant health and care professionals to deliver a multidisciplinary package of care. Monthly multidisciplinary review meetings were held for all patients considered to be at risk.

Mothers, babies, children and young people

The nursing team offered immunisations to children in line with the national immunisation programme. For those who had not attended on two occasions a letter was sent to the family and this information was passed to Health Visitors.

Contraception advice and services were provided by the Practice Nurse. A young person's clinic was facilitated and provided a confidential sexual health and contraception clinic for anyone of either sex under 25 years of age, no matter which GP surgery they attended.

The working-age population and those recently retired

The practice had identified the needs of the working age population and had adjusted their service to ensure improved access for these patients.

The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

Summary of findings

People in vulnerable circumstances who may have poor access to primary care The practice had identified patients with learning disabilities and treated them appropriately. There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation. The practice sign-posted vulnerable patients to various support groups and third sector organisations as necessary.	
People experiencing poor mental health Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with serious mental illnesses. Doctors had the necessary skills and information to treat or refer patients with poor mental health.	

Summary of findings

What people who use the service say

We spoke with 15 patients during our inspection. They varied in age and mobility. One person was pregnant and others had a long term condition. One patient whose second language was English told us there were no problems with cultural differences. They all informed us that staff were polite and helpful.

Patients told us they were involved with making decisions about their care and treatment. They all reported they were happy with the standards of care they received and several patients informed us that had been notable improvements to the service during the previous 12 months.

We collected 30 Care Quality Commission comment cards that we had left for patients. All of these comments were very positive. Patients described their care as perfect and excellent and that staff were caring and polite.

The practice carried out a patient survey in November 2013, also undertaken an independent analysis of their appointment system in February 2014 to seek patients' views. They also consulted with their Patient Participation Group (PPG). The outcome was an agreed change to appointment scheduling. We saw that the appointments system had already improved and that the full rescheduling was due to completed by September 2014.

Areas for improvement

Action the service MUST take to improve

Patients were not fully protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the dispensing of medicines. The practice must make sure that patient's medication prescription forms have been signed by a doctor prior to them being issued to patients.

Ramsey Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector**. The team included a GP, a specialist advisor Practice Manager, a CQC pharmacist inspector, a further CQC inspector and an expert by experience who had personal experience of using primary medical services.

Background to Ramsey Health Centre

At the time of our inspection there were five GP partners at the practice. There were two male and three female doctors. There was an advanced nurse practitioner and three other nurses and two healthcare assistants employed. There were two practice managers, four dispensary staff and an administration and patient services team of 10 staff. Ramsey Health Centre is a GP registrar training practice and at the time of our inspection there was a registrar GP and a foundation year 2 doctor training at the practice.

The practice does not provide an out-of-hours service. This is provided by a separate organisation.

Why we carried out this inspection

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

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 poor mental health.

We carried out an announced visit on 29 August 2014. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. During our visit we spoke with a range of staff including two GP's, the two practice managers, the advanced nurse practitioner, a practice nurse, a health care assistant, two reception staff and a three administrative

Detailed findings

staff. We also spoke with patients who used the service and two members of the Patient Participation Group (PPG). We observed how staff interacted with patients and reviewed records. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Our findings

Safe patient care

The practice demonstrated that it had a good track record on safety. We saw records that showed where concerns had arisen they had been appropriately reported as significant events and addressed in a timely way. The practice manager showed us there were effective arrangements in place that were in line with national and statutory guidance for reporting safety incidents. Records were kept of all clinical and non-clinical incidents and the practice manager took them into account when assessing safety. We saw examples of where improvements had been made to prevent similar occurrences. We saw minutes of the weekly reviews that GPs held for significant events. These events had been thoroughly analysed and included the learning that had been acknowledged and the actions that had been taken.

Health and safety preventative measures were in place to reduce the risks of unnecessary injuries to patients and staff.

Learning from incidents

There was a system for recording, reporting, monitoring analysing and learning from significant events that occurred at the practice. We were shown an incident where there was a missed referral and immediate action was taken and the issue was discussed with the patient.

We saw evidence that learning from incidents was shared with staff in a timely and appropriate way in order to reduce the risk of a similar incident occurring again. We saw evidence of robust communication processes with all relevant staff to ensure they were fully informed.

Official alerts about medical devices and medicines were shared with all clinical staff and where necessary actions had been taken.

Safeguarding

The provider had policies and procedures in place to ensure that patients were safeguarded against the risk of abuse. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their respective roles. Staff demonstrated they knew where to access the policies for safeguarding adults and children. Staff we spoke with were clear about how to identify concerns and when to report them and to whom. We saw that information about the local authority's safeguarding contact details were readily available to staff. There was close co-operation with health visitors which helped to identify children and risk and keep them safe. We saw leaflets were available, that advised patients who they needed to contact if they had concerns about abuse.

We saw evidence that demonstrated the practice was active and had worked with statutory agencies in safeguarding procedures in the detailed notes they had kept about safeguarding matters that related to children at risk, or on a Local Authority child protection plan.

The practice had a whistle blowing policy and staff demonstrated they were aware of it and their rights to use it if needed.

A written chaperone policy was available for staff to refer to. Posters were on display advising patients of their right to request a chaperone. Nurses and the health care assistant who acted as chaperones were aware of their responsibilities of this role.

Monitoring safety and responding to risk

There was a fire safety risk assessment in place. Staff had received regular fire safety training and participated in regular fire drills to maintain their knowledge of how to respond in a emergency. We saw that fire escape routes were kept clear to ensure safe exit routes. Emergency lighting had been tested monthly.

Annual checks for risks to the premises and of the environment had been carried out. Staffing levels and dealing with emergencies and equipment had also been risk assessed. The practice had a health and safety policy and health and safety information displayed for staff and for patients to see.

The practice had an identified health and safety representative

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. The dispensary was tidy and operated calmly with adequate staffing levels. We saw that repeat prescriptions that were being manually processed were handed to patients without proper authority from GPs when medicines were supplied to patients before prescriptions were signed by the GPs.

Records demonstrated that vaccines and all medicines including those for emergencies had been stored within

the correct temperature range. Staff described adequate arrangements for maintaining the cold-chain for vaccines following their delivery. Records used to monitor these medicines demonstrated that suitable arrangement were in place.

Controlled drugs were stored appropriately and were accounted for in line with the records kept by the practice. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. We found there was a comprehensive range of standard operating procedures for staff to follow and that these had been regularly reviewed and updated.

Dispensing staff had received appropriate training. The practice manager told to us that the competence of staff to dispense medicines had been assessed, and had been recorded in staff annual appraisals. The manager informed us that this would be included in the regular staff competency checks that they undertake.

Cleanliness and infection control

We saw that all areas of the practice were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

There were systems in place to reduce the risk and spread of infection. We saw that personal protective equipment (PPE) was in date including the privacy screening in clinical rooms. Staff we spoke with told us there were ample supplies of PPE. Hand sanitation gel was available throughout the practice and hand washing instructions above wash hand basins, including patient toilets.

We spoke with a nurse who was the designated lead for infection control. The practice issued an annual statement about Infection Prevention within the practice they had found that actions were necessary to put in place a deep cleaning schedule and continue with audits that had taken place for specific parts of the premises. The nurse practitioner carried out monthly checks of the premises and any issues were communicated to the cleaners for them to action.

The practice had a lead for infection control had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and there after annual updates.

There was a list maintained for recording employee's hepatitis B immune status. We found these were up to date.

Staffing and recruitment

The practice had a recruitment policy that stated the standards they would follow when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service.

We saw there was a rota system in place for the different staffing groups to ensure there was always sufficient staff on duty. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there was usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records that demonstrated that actual staffing levels and skill mix were in line with the practice's planned staffing requirements.

Dealing with Emergencies

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a device used to attempt to restart a person's heart in an emergency). All staff knew the location of this equipment. We saw records that confirmed this equipment had been checked regularly.

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

A business continuity plan was in place to deal with emergencies that may impact on the daily operation of the

Are services safe?

practice. Emergencies identified included power failure, adverse weather, unplanned sickness and access to the building and staff had details of the contact details necessary in the event of such emergencies.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Portable electrical equipment had been routinely tested and displayed stickers indicating the last test date. We saw evidence of the checks undertaken of fridge temperatures and of the accuracy of thermometers.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

The GPs and nursing staff we spoke with were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, assessments of patients' needs and these had been reviewed when appropriate.

The practice actively participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF) and local CCG led enhanced service schemes. QOF is a national performance measurement tool. CCG led enhanced services are schemes agreed in response to local needs and priorities. in which GP practices can choose to participate. The doctors had access to an online prescribing decision support system. The system ensured that the doctors were prescribing in line with national and local guidelines and that their prescribing decisions offered patients effective treatments. A pharmacist from the local Clinical Commissioning Group (CCG) had visited the practice to review prescribing habits and to offer advice.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made.

Management, monitoring and improving outcomes for people

The GPs told us clinical audits undertaken were often linked to medicines management information, or a result of information from the quality and outcomes framework (QOF), a national performance measurement tool. The practice used the information they collected for QOF as well as their performance against national screening programmes to monitor outcomes for patients. For example, 95% of patients with diabetes had an annual medication review and the practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease, dementia diagnosis and detecting cancer. The practice was not an outlier for any QOF clinical targets.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and patients experiencing poor mental health.

We received feedback from a local care home who described how the practice was mindful of reducing antibiotic prescribing and had monitored several patients who had been prescribed antibiotics. This had ensured that the GPs decision to treat with antibiotics was an effective treatment.

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

Staffing

The practice employed staff who were appropriately skilled and qualified for their role and supported them with an effective training regime. This included an induction process where new employees were mentored through a three-month probationary period. We saw that training was monitored by the practice manager to ensure that staff received updates on key aspects of their role according to a schedule.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. We saw that arrangements were in place to ensure that all clinical staff were revalidated in accordance with their professional registration by means of continuing professional development. The practice nurse was supported to receive annual updates in key aspects of their role, such as respiratory disease and diabetes and immunisation.

As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended

Are services effective?

(for example, treatment is effective)

appointments and had access to a senior GP throughout the day for support. Feedback from a first year doctor and from a GP trainee we spoke with confirmed that they were appropriately supported by senior GPs.

An effective appraisal process was in place. We spoke with the practice nurse who shared with us the outcome of their appraisal. We saw that they received regular annual appraisals from GPs and that learning opportunities had been identified and discussed and arrangements put into place to meet learning needs. This process was being implemented for all other members of staff. Practice nurses and a healthcare assistant had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example: administration of vaccines, cervical smear tests, minor injuries and phlebotomy. Those with extended roles for cryotherapy (a process for use of low temperatures to treat benign and malignant tissue damage) and seeing patients with long-term conditions, such as asthma, or diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

Working with other services

The practice operated an email notification system with the out-of-hours service. This enabled the efficient exchange of information about patients using the out-of-hours services and ensured any follow-up action could be taken by the practice if required. We also saw that the practice shared key information with the out-of-hours service and the ambulance service about patients nearing the end of their lives. This included information in relation to decisions that had been made about resuscitation in a medical emergency. This ensured that patients' preferences about their death could be fulfilled.

Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. Staff had clear responsibilities for reading, recording and passing on any issues arising from these communications on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Patients who lived in the three local care homes received regular attention and home visits from a named GP. This arrangement was made under an NHS enhanced service scheme for the practice. The practice had worked very closely with these residential services and this had ensured regular home visits and urgent care had been provided.

At the time of this inspection the practice was participating in a multi-professional clinical study (CARE MED) initiated by the University of East Anglia to review medication. The practice chose to become involved in this study to improve the use of medication for patients that included elderly patients, those with mental illness, learning disabilities and physical disabilities.

We saw that where the practice had identified safeguarding risk to children there had been many occasions when they had worked alongside the Local Authority children and family teams and the Police in safeguarding matters as part of a multi-agency co-ordinated response. The practice held regular monthly multidisciplinary team meetings to discuss the complex needs of patents with end of life care needs. The practice also met to discuss children who were subject to a child protection plan. These meetings were attended by district nurses, social workers, palliative care nurses where decisions about care planning were documented in a shared care record. GPs and clinical staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Health, promotion and prevention

The practice manager told us all new patients were offered a health check and a review of any illness and medicines they were taking. We saw evidence that these annual health checks and medication reviews had taken place. Patients who were due for health reviews were sent a reminder and if necessary contacted and asked to make an appointment. Patients were also asked about their social factors and lifestyles. This ensured clinical staff were aware of the wider context of patients' health needs.

Patients told us they had been encouraged to take an interest in their health and to take action to improve and maintain it. We saw a variety of health and welfare information, in leaflet form, displayed in the waiting area for patient to take away with them. Regular well person clinics were held for patients to attend and receive advice about healthy living standards.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed patients being treated with dignity and respect throughout the time we spent at the practice. We saw that clinical staff displayed a positive and friendly attitude towards patients and we observed reception staff greeted patients in a polite and courteous manner. When appointments were made by telephone we heard receptionists giving patients choices and respected patients' decisions about attending on certain days.

The 30 comment cards that patients had completed gave us very positive feedback about the staff. No one we spoke with, or any of the written comments were negative about the service. Several patients confirmed that a chaperone service had been offered to them by clinical staff. A few patients told us they had used the chaperone service and said they felt quite comfortable with the process.

There was a privacy and dignity policy in place and all staff had access to this. We saw that all clinical rooms had window blinds and privacy screening. Clinical staff told us the consulting room door was kept closed when patients were being seen. We observed that staff knocked on doors and waited to be called into the room before entering.

One patient explained that following a bereavement a GP had contacted the family by phone to offer them support and an appointment and to inform them of the bereavement counselling services available to them. The practice manager told us this response was usual following a bereavement and would apply to all families.

Involvement in decisions and consent

A nurse told us that she explained treatments and tests to patients before carrying out any procedures. Patients were given an explanation of what was going to happen at each step so that they knew what to expect. Patients told us they felt that they had been involved in decisions about their own treatment and that the doctor and nurses had given them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

We saw the practice's consent policy and a guide to the Mental Capacity Act 2005 (MCA). These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. Clinicians were aware of patients who needed support from carers and ensured that carers' views were listened to as appropriate. Two residential care homes confirmed that for patients who lacked capacity, the GPs had ensured that patients were included in discussions. They told us that patients were always given the opportunity by the GP to respond and that carers and relatives were included in decision making to ensure that patients' best interests were promoted.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and had taken appropriate steps to tailor the service to meet the population needs. The practice had a higher than average older population group on their list. We were shown the measures the provider had taken to target patients with coronary heart disease, dementia and depression and regular medication reviews and regular testing for patients taking anticoagulation drugs.

Young people were offered a sexual health advice and screening clinic service. General health was promoted to patient through the well woman and well man health clinics provide by the practice. A minor injuries clinic and a cryotherapy (use of low temperatures to treat lesions) clinic was led by the Senior Practice Nurse after referral via a GP.

We found that patients with learning disabilities or mental health conditions were offered an annual health review. Patients aged 65 and over were also offered annual health checks. The practice nurses visited housebound patients in their homes to review their care needs and to offer flu vaccinations. We were told that non-residents would be seen as temporary patients, should this be necessary. Several other health professional were facilitated to provide a health service at the practice. These included: a podiatrist, a clinical psychologist, an orthoptist (a clinician who diagnoses and treats defects of binocular vision and abnormalities of eye movement.) a hearing aid clinic, a speech a language therapist, a mental health team and a young people's sexual health specialist.

There was an active Patient Participation Group (PPG) who interacted regularly with practice staff through regular meetings. We found that improvements had been made as a result of a patient survey and this had been communicated via a quarterly newsletter that the practice publish.

When patients requested an appointment whose first language was not English reception staff had automatically arranged for a telephone interpreter service. We were informed that the numbers of non-English speaking patients known to the practice was minimal.

Access to the service

Patients could make appointments by telephone, or in person at the practice. Ramsey health Centre offered extended hours one evening per week until 8pm, for the convenience of people who could not attend during the day. All of the patients we spoke with told us they could make urgent and routine appointments when they needed them. Appointments could be made with a doctor, or the nurse practitioner for minor ailments.

Reception staff told us that patients who requested to be seen urgently were offered a same day appointment. They added that requests for appointments for children were treated as urgent, same day appointments.

We asked patients about waiting times. We were told by some patients that their routine appointments involved a longer waiting time than they would have chosen, although the fully understood the priority for urgent appointments. We found that requests for home visits were triaged by the duty doctor who telephoned the patient to check the visit was essential. We saw evidence that urgent home visits were carried out on the dame day.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. There was information about the complaints process in the practice leaflet.

The 15 patients we spoke with told us they had not had any cause to complain. Similar comments were made in the 30 patients comment cards that we received.

We saw the practice's log and annual review of complaints it received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting.

Are services well-led?

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

Our findings

Leadership and culture

Ramsey Health Centre had information for patients published on their web page about their commitment to high standards of patient medical care in a friendly manner that was receptive to ideas and suggestions and was shared by the entire practice team. Staff we spoke with demonstrated their understanding and willingness to uphold these standards and we saw evidence that showed that staff put into action these standards.

All the staff we spoke with said they felt valued and respected by the GPs nurse and practice managers. Staff told us they attended regular practice meetings.

During our inspection the practice manager and a GP provided the inspection team with information about the improvements they had made during the previous twelve months. This included more regular practice meetings and staff meetings and an open and transparent leadership. It was evident they had listened to opinions made by staff, patients and the Patient Participation Group (PPG) and had carried out their own investigations. The improvements implemented had resulted in greater staff satisfaction.

Governance arrangements

There was a clear governance structure at the practice that provided assurance to patients and Clinical Commissioning Group (CCG) that the service was operating safely and effectively. There were clearly defined lead roles for areas such as safeguarding and information governance and enhanced services and for checking that the number of GP sessions met patients' needs. These responsibilities were shared between the doctors, nurses and practice managers.

Whilst there was a system in place to assess the competency of staff to dispense medicines, there was no documentary evidence to support this. Therefore, we could not be assured that dispensing staff performance had been regularly assessed as satisfactory.

Systems to monitor and improve quality and improvement

The practice had a system to assess and monitor the quality of service that patients received. We saw the provider carried out a number of audits designed to assess the quality of its services. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice was able to demonstrate that it was meeting the required QOF targets. In addition to monitoring and reporting its performance against the national quality requirements, the provider had developed and agreed quality indicators with the local CCG. The indicators were monitored and performance was reported to the CCG.

There was also a system in place to monitor repeat prescriptions which we saw had been used to assist the review of medication to all patient groups.

Patient experience and involvement

We found there were strong, positive relationships between practice staff and the Patient Participation Group (PPG). We looked at the surveys conducted with the PPG which had resulted in a process to keep both parties informed and updated. They also included progress against any areas where improvements had been made such as, the appointments system. During our visit we spoke with two members of the PPG. They were very positive about the relationship they had with practice staff and felt their recommendations were listened to and acted on.

Staff we spoke with told us they felt well supported and were able to express their views about the practice. They said they were encouraged to make suggestions for improvements and these were taken seriously by senior staff.

Learning and improvement

We saw evidence that learning from significant events and from complaints and from patient surveys took place and changes implemented to reduce similar occurrences. We saw there were processes in place for practice staff to audit and review significant events and appropriate action plans had been implemented and disseminated to staff during meetings to ensure that learning was established.

The practice GPs had initiated a drug group discussion for learning and improving practice, as part of their weekly clinical meeting. The system to monitor repeat prescriptions had resulted in further learning about medicines and that decisions about medication became a team issue to include in clinical meetings.

Identification and management of risk

There was no formal register of corporate risks at the practice but we saw evidence that risks had been identified and action taken to minimise their potential impact. For

Are services well-led?

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

instance, there was a contingency plan to deal with loss of use of the building or loss of utility services in the building. The risks associated with the increased patient population and associated demand had been brought to the attention of the practice by patients and the Patient Participatory Group.

The practice had managed this by commissioning an independent report and as a result, the practice subsequently managed the risk that patients needing urgent appointments would be guaranteed of being seen by a GP or nurse on the same day.

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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.

Our findings

The practice actively invited older people to attend surgery for flu vaccinations. Patients who attended for flu vaccinations or a health check were always offered additional relevant health information. Housebound patients were visited by the doctor or a nurse for routine flu vaccinations.

The practice also targeted patients over 75 to offer them a vaccination against shingles. All patients over the age of 75 had a named GP to help achieve continuity of care and reduce risk to patients. Patients in this group had been informed by letter who their named doctor was. The practice undertook work to review older patients who had frequent unplanned hospital admissions and readmissions. This was to identify any unmet health needs or a need to educate patients about managing their conditions to prevent subsequent admissions.

The practice held a register of elderly patients with dementia and ensured that they were offered regular health checks.

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).

Our findings

The practice ran regular clinics for patients with long-term conditions such as diabetes, chronic obstructive pulmonary disease, cardiovascular disease and asthma. We saw the practice followed a call and recall protocol to ensure that as many patients as possible with long term conditions regularly attended for a review.

The practice had identified patients with poorly controlled diabetes and invited them to additional educational meetings to support the self-management of their condition.

The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives.

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.

Our findings

The practice offered lifestyle advice to pregnant patients. New mothers were given written information and advice on breast feeding, immunisation schedules, first aid, and the safe storage of children's medicines.

The practice held a nurse led baby clinic every week and offered every new mother a postnatal check six weeks after the birth of their baby. The practice delivered the full range of childhood immunisations.

There was a separate area in the waiting room for children and patients with young children. Sexual health for young people and for mothers was promoted through a specific service working from the practice that offered a range of advice and referrals to other specialist centres.

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.

Our findings

The practice was open for extended hours on one night a week to enable people working people to make appointments outside of their normal working day. Patients could also consult the doctors by telephone and online rather than visiting the surgery.

The surgery offered an in-house service to take patients' blood for testing. However, patients could be referred to a local hospital to have their blood taken if they wanted an appointment earlier than the practice opened.

Patients could choose to be referred for further treatment or investigation at a hospital closer to their place of work if required.

The practice ran regular well woman and well man clinics and regular cervical smear testing with recall periods dependent on identified risks.

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).

Our findings

The practice had identified and kept a register of patients who had learning disabilities and treated them appropriately. Those patients who failed to attend for their annual reviews were contacted by phone and if necessary their family and carer. We were told that the learning disabilities team would be contacted for patients who failed to attend for their annual reviews. The practice had carried out annual health checks for people with learning disabilities and 95% of these patients had received a follow-up. The practice offered longer appointments for people with learning disabilities.

There was one homeless person no travellers registered with the practice, but the GPs and the practice manager confirmed that they would be able to register with the practice.

Patients were encouraged to participate in health promotion activities such as contraception advice, cervical screening, smoking cessation and flu vaccinations.

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.

Our findings

The practice held a register of its patients known to have poor mental health. The practice was in the process of developing individual care plans for each patient on the register. Annual health checks were offered to patients with serious mental illnesses and we found that 94% of these patients had received an annual health check. Doctors had the necessary skills and information to treat or refer patients with poor mental health to specific services and support groups in third sector organisations, such as MIND. The practice staff worked with the local mental health team and community psychiatric nurses to ensure patients had the support they needed. Counselling services were available at the practice from a visiting counsellor.

Ramsey Health Centre held a register of patients with dementia, which included early onset dementia and ensured that these patients were offered regular health checks. The practice worked regularly with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. We saw that advance care planning was in place for these patients and that carers were involved in these plans.

The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs.

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
Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Judgement** Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe dispensing of repeat prescriptions of medicines.