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.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ranworth Surgery on 14 July 2015.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, safe, effective, caring, responsive and well-led services. It was also good for providing services for the people with long term conditions, families, children and young people, working age people (including those recently retired and students), and people experiencing poor mental health (including people with dementia) and outstanding for providing services for older people, and for people whose circumstances may make them vulnerable.

Our key findings across all the areas we inspected were as follows:

- Staff understood how to report significant events and to raise concerns. Actions were taken following investigations into significant events, and these were reviewed to evaluate their impact.
- Risks to patients were assessed and well administered, with evidence of action planning and learning when needed addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with compassion, dignity and respect and said they were involved in their care and decisions about their treatment.
- The practice performed above average in a range of areas surveyed in the national GP patient survey published in July 2015.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- The majority of patients said they found it easy to make an appointment with a GP and that there was continuity of care. We were told urgent appointments were available the same day.
- The practice had appropriate facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff told us they felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

We saw two areas of outstanding practice:

- The practice provided a specific, enhanced, primary care service to homeless people in the local area not provided by other local practices.
- The practice had established a 'Care Home' service where their GPs held a surgery once a month in selected care homes; the appointments for patients were pre-booked enabling their families to attend with them. This was provided to benefit their patients with a more holistic care model and reduced stress for the patient, their family and for care home staff.

However there was an area of practice where the provider needs to make improvements.

Importantly the provider should:

- Ensure patients are provided information in the waiting room or at the reception desk to guide them if they want to make a complaint.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learnt and communicated to staff during weekly meetings. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff on the rota each day to keep patients safe.

Safety alerts were appropriately managed and actions recorded. Emergency medicines and vaccinations were correctly stored and monitored and the practice was able to respond to medical emergencies safely.

There were robust infection control procedures in place to protect patients from the risk of acquiring healthcare related infections. There were appropriate staff recruitment procedures in place, and an appropriate number of clinical and non-clinical staff employed to deliver the service reliably.

Arrangements were in place for chaperones to be available for patients when required.

There was a business continuity plan in place to ensure business continuity during periods of fluctuating demand, or in the event of an emergency that may impact on the daily operation of the practice.

Are services effective?

Good

The practice is rated good for providing effective services. Data showed patient outcomes were similar to expected and average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely.

Patients' care was planned and delivered in line with current legislation and clinical governance. Clinical audit was used to inform clinical effectiveness, this included assessing and promoting good health. Staff had received appropriate training for their roles and further training needs were identified and appropriate training planned. There was evidence of staff appraisals and personal development plans.

Clinical practice, including consent and prescribing, was delivered in accordance with nationally recognised best practice for primary care. The clinical staff held weekly meetings to discuss patient care and practice services.

Summary of findings

The practice worked in partnership with other services to meet the needs of their patients. Patients had access to a variety of health promotion information and services that promoted a healthy lifestyle and their health needs were assessed promptly and routinely reviewed.

Are services caring?

Good

The practice is rated as good for providing caring services. The findings from data published in July 2015 in the national GP survey showed that patients rated the practice higher than others in the local area for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We observed that staff treated patients with kindness and respect, and maintained confidentiality when greeting them at the practice. Patients and carers described the service very positively.

The practice considered the diverse needs of their patients and took action to meet them. We saw evidence that patients were asked for their consent to care prior to treatment.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Patients said they were able to make an appointment with a named GP and could have continuity of care. We saw urgent appointments were available on the same day in the morning surgery. The practice had adequate facilities and was equipped to treat patients and meet their needs. Information about how to complain was available on the practice website with links for easy access to organisations that supported patients who had a complaint. Evidence seen showed that the practice responded quickly to issues raised. Learning from complaints was shared during staff meetings or by internal communication if more urgent. We did note there was no access to information in the waiting room or reception area to support patients if they had a complaint.

The practice provided an enhanced service to homeless patients living in Clacton and had been providing this service for four years. They also provided a 'Care Home' service where their GPs held a surgery once a month in selected care homes. The practice manager also told us the practice was in the process of establishing a service for a local learning disabilities home.

Summary of findings

A local clinician visiting the practice who provided long term condition support to the patients and spoke extremely positively about the practice's responsiveness and ability to meet the needs of their patients.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy lay out in their statement of purpose. There was a well-defined leadership structure and staff told us they were well supported by management.

The practice had a number of policies and procedures to administer activity; we found these were regularly reviewed and up to date. The practice held regular clinical and staff meetings to keep staff updated regarding practice issues. There were procedures in place to monitor and improve patient outcomes, service quality, and identify risks.

The practice patient participation group (PPG) had 25 members with an age range of 35 to over 75 years of age; they gave support to the practice with patient opinions, regarding any proposed changes at the practice. The PPG produced questionnaires to ask patient opinions about the services provided at the practice. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and were provided

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were similar or above the local and national average for conditions commonly found in older people. The patients on the hospital admission avoidance list at the practice had a regular reviews and an agreed care plan in the patient's home and on the practice records. Staff were responsive to the needs of older people, and offered home visits and rapid access to appointments for those who were frail or in need. This group of patients had a named GP to provide consistency of their care.

The clinical team met with the local palliative care and hospice teams monthly to discuss patients on the practice end of life register. The practice took part in an 'End of Life' scheme that encouraged patients receiving palliative care to make decisions about their preferred place of care and about 'Do Not Resuscitate' options. This has resulted in more patients' wishes for care being met to reduce stress for themselves and their families.

The practice had established a 'Care Home' service where their GPs held a surgery once a month in selected care homes; the appointments for patients were pre-booked enabling their families to attend with them. This was provided to benefit their patients with a more holistic care model and reduced stress for the patient, their family and for care home staff.

Staff had been trained in-house to respond to patients and family needs during difficult times. The practice had an identified GP clinical lead for end of life care, and there was designated administrative support at the practice to follow-up and liaise with the clinical teams for older patient issues. Carers were identified and offered appropriate support.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

There was provision for chronic disease management clinics for patients with asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease CHD.

Using the nurse practitioner for minor illness and injury had enabled greater provision of appointments with the nursing staff for patients with long term conditions. Carers were identified and offered appropriate support.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were procedures in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example children and young people who had a high number of A&E attendances. Immunisation rates were higher for all standard childhood immunisations than other practices in the local area. Patients told us that children and young people were treated in an age-appropriate way and very supportive when attending for immunisation. Appointments were available outside of school hours and the premises were accessible for children and parents with pushchairs. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice had altered their appointment system to provide ease of access for families. The GP on duty had the flexibility to see children promptly and the ability to review again on the same day if necessary. High achievement targets for childhood immunisation reflected their values regarding childhood health promotion.

The practice worked closely with the local maternity services to fully support and work alongside their midwife service. The practice provided both antenatal and post-natal care.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted their opening hours and the services to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this population group.

A range of enhanced services was available, for example 'Extended Hours Access'. This enabled patients to consult a health care

Summary of findings

professional, face to face, by telephone or by other means at times other than during core practice hours. 'The practice provided minor surgical procedures as part of the primary medical services to reduce the need to access an acute care provider.

The practice offered website bookable appointments, and they had increased the number of appointment slots to suit this population group. New patients were provided a health check when they registered at the practice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including, the homeless and those with a learning disability. The practice had committed to a Locally Enhanced Service (LES) to treat homeless people for the local area. A LES is a primary medical service locally agreed according to local demographic need other than a core essential GP contract service. The practice manager told us from the receptionists through to the GPs all staff members knew how to act, care, and treat patients in need of this service provision. The practice provided this service for patients in the Tendring area of the Clinical Commissioning Group.

The practice manager also told us the practice was in the process of establishing a service a local the learning disabilities home. The GPs planned to provide a regular surgery at the home to reduce the stress for the learning disability patients, and the care staff.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Communication with vulnerable patients about how to access various support groups and voluntary organisations was incorporated into the management of this population group.

Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact to raise concerns. One GP at the practice was the lead for safeguarding issues, and staff, when asked, could identify who was the lead.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The majority

of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

We were shown the commitment to the 'Dementia' enhanced service. The practice carried out advance care planning for patients with dementia designed to facilitate timely diagnosis and support people with dementia. The practice had a higher than average diagnosis rate for the area, and continued to screen and diagnose where appropriate after the enhanced service was no longer funded, to meet the needs of their population.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. They had a procedure in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training to care and respond to people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages. There were 114 responses which represented 6.1% of the practice population.

- 90.9% found it easy to get through to this surgery by phone compared with a Clinical Commissioning Group (CCG) average of 72.7% and a national average of 74.4%.
- 94.7% found the receptionists at this surgery helpful compared with a CCG average of 85.6% and a national average of 86.9%.
- 76.4% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 61.7% and a national average of 60.5%.
- 93.5% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 72% and a national average of 73.8%.
- 97% said the last appointment they got was convenient compared with a CCG average of 92.6% and a national average of 91%.
- 93.7% described their experience of making an appointment as good compared with a CCG average of 72% and a national average of 73.8%.
- 62.7% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 59.3% and a national average of 65.2%.
- 62.7% felt they don't normally have to wait too long to be seen compared with a CCG average of 56.7% and a national average of 57.8%.

We spoke with eight patients during the inspection, and they gave us positive comments regarding the services provided by the practice. Patients told us they could obtain an emergency/on the day appointment when they requested one. One patient told us they had been waiting over half an hour for their appointment which thought was too long. All the patients we spoke with told us they were treated with dignity and respect by the clinicians and the majority of the non-clinical staff members.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards which were all positive about the standard of care received. Most referred to the staff as kind and helpful. Some of the patients reported that they felt listened to and were involved in decisions and choices about their care.

Areas for improvement

Action the service SHOULD take to improve

- Ensure patients are provided information in the waiting room or at the reception desk to guide them if they want to make a complaint.

Outstanding practice

- The practice had established a 'Care Home' service where their GPs held a surgery once a month in selected care homes; the appointments for patients were pre-booked enabling their families to attend with them. This was provided to benefit their patients with a more holistic care model and reduced stress for the patient, their family and for care home staff.

Ranworth Surgery

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 Care Quality Commission GP specialist advisor, and a Care Quality Commission practice nurse specialist advisor.

Background to Ranworth Surgery

Ranworth Surgery is a three GP partner practice employing one salaried GP, and a GP trainee. The practice serves approximately 7600 people living in the Clacton on Sea area. The practice holds a primary medical service (PMS) contract to provide their services.

The GPs, four male and one female, are supported by one nurse practitioner, three nurses, two healthcare assistants, a phlebotomist, a team of 13 administrative/reception staff, and a practice manager

The practice is open between 8am and 6.30pm Monday to Friday. They provide two late nights from 6.30pm to 7.30pm and one early morning from 7.30am to 9.00am. There is an open surgery (no need to book) between 10.30am to 11.30am Monday to Friday. We were told the practice constantly monitored the access and use of appointments and adjusted the times of them to meet patient requirements.

The practice has opted out of providing 'out of hours' services which is now provided by Care UK. Patients can also contact the NHS 111 service to obtain medical advice if necessary.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked a healthcare professionals to share what they knew. We carried out an announced inspection on 14 July 2015. During our visit we spoke with a range of staff including GPs, nurses, the practice manager, receptionists, administrators, and the prescription clerk. We also spoke with patients that visited the practice on the day of the inspection. We observed how people were being cared for and talked with and reviewed the practice policies and procedures.

Before we visited we provided comment cards for patients to complete about their experiences at the practice and reviewed the nine that had been completed. We also spoke with partner organisations and healthcare professions in the area for their views regarding the practice.

Good

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. We saw meeting minutes, where risks had been discussed. For example a review of safety alerts from the Medicines and Healthcare Regulatory Authority (MHRA). The practice manager showed us their procedure to deal with safety alerts at the practice and we were assured that these had been acted on and dealt with appropriately. Staff we spoke with knew how to report significant events, and we saw records of events that had been reported during the last year. We saw significant events were also discussed at staff meetings. The annual review of six safety incidents showed the practice had managed these consistently over time and to show evidence of a safe track record over the long term.

We reviewed safety records, and incident reports showing the lessons they had learned. We tracked six incidents and found that records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared.

Significant events and complaints were a standing item on the meeting agendas when an incident had occurred we saw they reviewed and talked about the actions to take from both significant/safety events in the meeting minutes. This evidenced the practice learned from these and findings were shared with staff members. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and felt encouraged to do so. The practice was open, honest and transparent when mistakes had occurred thus displaying a duty of candour.

National patient safety alerts were disseminated by the practice manager to the appropriate practice staff. Staff we spoke with also told us alerts were discussed at clinical meetings to ensure staff were aware of any that were relevant to the practice and where needed the action to take. The practice manager kept a record of alerts that the practice had received and acted on.

Overview of safety systems and processes

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that staff had received relevant role specific training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding how to share information, properly record the documentation of safeguarding concerns and who to contact.

The practice had appointed a dedicated GP as their lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. All staff members we spoke with were aware who the lead was and who to speak within the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We were told there was practice engagement in local safeguarding procedures and effective working with other relevant organisations these included health visitors, local learning disability care staff, and the local authority.

There was information for patients about requesting a chaperone on a notice in the waiting room. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice chaperone policy had been regularly reviewed and was up to date. The nursing staff, and health care assistants, that provided chaperone support for patients had been trained and held a disclosure and barring service (DBS) certificate. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The nursing staff who provided the chaperone service understood their responsibilities when acting as a chaperone, including where to stand to be able to observe the examination.

We checked medicines and medicine fridges and found vaccines were stored securely. There was a policy to ensure medicine was kept at the required temperature, with a description of the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out and medicines were being stored at the appropriate temperature.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were appropriately checked and suitable for use.

Every prescription was reviewed and signed by a GP before they were given to the patient. Both blank prescription forms used in printers and those forms for hand written prescriptions were handled in accordance with national guidance and tracked through the practice and kept securely at all times.

We saw audit records and clinical discussion notes that documented the actions taken in response to an audit review of meeting the guidelines for prescribing a high risk medicine. The results showed that prescribing against guidelines was improving the monitoring of patients. There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which required patients to have regular blood monitoring in accordance with national guidance. We saw that appropriate action had been taken based on patients' results, and where patient care was shared by the hospital this was recorded and kept up to date on patients' records.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. PGDs are specific guidance on the administration of medicines including authorisation for nurses and healthcare assistants to administer them. We saw the PGDs used by the nursing staff had been reviewed and were updated this year.

We observed the premises and environment to be visibly clean and relatively tidy although the building presented the practice with challenges to achieve this as half the practice site was old. We noted the majority of the rooms at the practice had storage issues making it feel disorganised and in some places cluttered. We saw there were cleaning schedules in place and cleaning records were checked. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control.

An infection control policy was available to support staff. This included infection control procedures, the management of needle-stick injuries and clinical waste management. The policy gave guidance to staff regarding, personal protective equipment, disposable gloves, aprons and coverings that we saw were available for staff to use.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff received induction training about infection control specific to their role. We saw evidence that the practice had carried out an audit and identified improvement areas. The practice mitigated risks identified by regular monitoring. For example there were notices concerning hand hygiene techniques displayed in staff and patient toilets. Hand washing sinks had liquid soap, hand gel and paper towels available.

Staff we spoke with told us they had sufficient and adequate equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records that showed effective arrangements were in place to check, service and recalibrate all clinical pieces of equipment. For example, medical screening equipment was recalibrated in accordance with manufacturers' instructions, and records supported these arrangements, such as portable appliance testing that showed equipment was suitable for use.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at five staff files and they contained evidence that appropriate recruitment checks had been undertaken for recently employed staff members prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice manager provided us with evidence about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We were shown the way the practice measured demand to ensure that enough staff members were on duty. The staff

Good

Are services safe?

told us there was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written within their contracts.

Staff told us there were enough staff to maintain the smooth running of the practice and there was always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy that was displayed for staff and patients to see. A member of staff at the practice had been allocated the responsibility for health and safety at the practice.

When identified, health and safety risks were added to a risk log and each risk was assessed and actions were recorded to reduce and manage them. We saw evidence in meeting minutes these had been discussed in staff meetings and actions and learning points had been acted on.

There were monitoring systems in place for patients with long-term conditions. Staff told us referrals were made for patients whose health had deteriorated suddenly and explained how a summary of their care was sent with the patient to ensure healthcare professionals they had been referred to had current and up to date information to treat them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this emergency equipment and records confirmed that it was checked regularly. We found that the pads for the automated external defibrillator were within their expiry date and suitable for use.

Emergency medicines were accessible to staff in a safe area of the practice and staff knew the location. These included medicine for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not treated, and hypoglycaemia, or low blood sugar, is a common problem for people with diabetes. Processes were also in place to check whether emergency medicines were within their expiry dates 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 a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. The plan was available to staff and was last reviewed in 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were shown they could be accessed easily from their computers desktops.

We saw within meeting minutes that clinical updates were discussed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. Staff explained how care was planned to meet identified patient needs and were reviewed six monthly to ensure their treatment remained effective. For example, patients with diabetes had regular health checks and were referred to specialist services when required.

The GPs told us they led in specialist clinical areas such as diabetes, minor surgery and safeguarding, and the practice nurses supported this work. Clinical staff we spoke with told us they liaised with each other to use their specialist knowledge and were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital as part of the admission avoidance work they were involved with. This work included developing a written and electronic personalised care plan collaboratively, with the patient and their carer (if applicable). The care plan was jointly owned by the patient, carer (if applicable) and named accountable GP. These patients were reviewed regularly to ensure the multidisciplinary care plans were documented in their records and their needs were being met, to assist in reducing the need for them to go into hospital. We were told when high risk patients were discharged from hospital they were followed up to ensure their needs were met.

Discrimination was avoided when making care and treatment decisions. We were told the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. This formed part of the practice's statement of purpose for patients.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input and analysis, scheduling clinical reviews, managing child protection and safety alerts, and medicines management. The information staff collected was collated by the practice manager and data analyst to ensure the practice could carry out clinical and administrative audits.

The practice showed us two clinical audits that had been undertaken in the last year. Both of these audits showed where the practice was able to demonstrate changes resulting from the initial audit. For example clinicians now followed the 'Diabetes UK' recommended guidance for patients with impaired glucose regulation (IGR). IGR is a term that refers to blood glucose levels that are above the normal range but not high enough for the diagnosis of 'Type 2' diabetes. When they reviewed patient diagnosed with IGR the practice found that by meeting the recommended guidance, patient risks of heart disease could be treated and future complications prevented, thus improving patient outcomes.

The GPs told us clinical audits were often linked to the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98.1% of the total QOF target in 2014, which was 4% above the national average of 94.2%. Specific examples to demonstrate this included:

- The percentage of patients with diabetes, on the register, for whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less. This was 83.86% compared with the national average of 78.53%.
- The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who were treated with an appropriate bone-sparing agent was 90.91% compared with the national average of 81.27%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months was 88.57% compared with the national average of 83.82%.

Good

Are services effective?

(for example, treatment is effective)

The clinical staff we spoke with told us how in their weekly clinical partners meetings they discussed and reflected on the outcomes being achieved and areas where this could be improved.

The practice's prescribing rates were also similar to national figures, although there were two medicines that were higher than national average that the practice was aware of. The practice was looking at these prescribing rates and attributed the high occurrence on the treatment of a specific group of people in the area. There was a policy for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question.

The practice had a palliative care register and had regular internal and multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example the homeless, and learning disabilities. Structured annual reviews were undertaken for people with long term conditions for example diabetes, chronic obstructive pulmonary disease (COPD), and heart failure.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff members had attended role related training courses and annual basic life support.

We noted there was a good skill mix among the GPs in clinical areas such as diabetes, minor surgery and child protection. All GPs were up to date with their yearly continuing professional development requirements or had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example first aid training, smart card training, and health and safety.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, infection control and dressings update.

Coordinating patient care and information sharing

The practice worked with other service providers to meet patients' needs and support those patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a procedure outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues that arose in these communications. Out of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and action taken on the day of receipt. The GPs who saw these documents and results were responsible for the action required. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were similar to the expected rate. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We were shown the procedure used to act on hospital communications to ensure that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs. For example, those with multiple long term conditions, those with a learning disability and those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about

Good

Are services effective?

(for example, treatment is effective)

care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

The practice used several electronic systems to communicate with other providers. For example, there was a system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services. Information from the out-of-hours service provider was checked on a daily basis and flagged to the relevant GP for them to action. The practice used the 'Choose and Book' system to book hospital outpatient appointments for patients and they told us this system worked well for the patients. 'Choose and Book' is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

For patients who were referred to hospital in an emergency there was a procedure to provide a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system which enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice used the local GP care-advisor service; they told us the advisor assigned to them was proactive and dealt with GP patient referrals to manage specific non-clinical needs. The care advisor supported patients from this population to find alternative non-clinical solutions for their issues and worked closely with the clinical team to feedback on their progress and any developments.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. When asked clinical staff demonstrated an understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice procedure for documenting consent for specific interventions. For example, for minor surgical procedures, consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Clinical Commissioning Group (CCG) to help focus health promotion activity.

The practice offered a health check to new patients registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic life style advice and smoking cessation advice to smokers.

Data we held about this practice showed:

- The percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding 5 years was 80.19% compared to the national average of 81.88%.
- The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months was 96.91% compared to the national average of 95.28%.

The practice had many ways of identifying patients who needed additional support, and was pro-active in offering

Good

Are services effective?

(for example, treatment is effective)

additional help. Mechanisms to identify 'at risk' groups were used for patients who needed dietary advice and those receiving end of life care. These groups were offered further support in line with their needs.

Patients had access to a range of information to support them to achieve and maintain healthy lifestyles. Written information was available at the practice, about common medical conditions, support agencies, immunisations and other health promotion issues. The practice website had links to useful health advice; for example 'NHS Choices Your health, your choices'. Posters and leaflets displayed within the waiting area informed patients of the range of health and social care services available that may meet their current needs.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw patients were treated with dignity and respect by staff when being greeted by reception staff and in answering patient enquiries. There was information available in the waiting room informing patients that they could request to speak with staff in private if they needed to speak confidentially. We saw how staff observed patient confidentiality discussing matters quietly and sensitively to mitigate the risk of being overheard. Staff checked patients' identity by using their dates of birth rather than their name. A touch screen facility was available for patients to check-in for their appointments without the need to discuss health concerns at the reception desk.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey published in July 2015, 321 survey forms were distributed for this practice and 114 forms were returned providing a response rate of 35.5%.

Before our inspection we left comment cards for patients to complete to give their views on the practice. We received nine completed comment cards. There all contained very positive comments revealing information about their excellent treatment by staff and describing staff as friendly, respectful and helpful.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey 2015 showed:

- 94.7% of patients found receptionists at the surgery helpful compared to the Clinical Commissioning Group (CCG) average of 85.6% and national average of 86.9%
- 98.8% of patients had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 97.5% and national average of 97.2%.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. Staff had been trained in-house to respond to patients and family needs during difficult times

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed, published in July 2015, showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice similar to other practices in these areas. For example:

- 95.1% of patients who responded said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 83.7% and national average of 86.3%.
- 92.1% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79.9% and national average of 81.5%.

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

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

The patient survey information we reviewed published July 2015 showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

Good

Are services caring?

- 90.9% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83.8% and national average of 85.1%.
- 96.8% s of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90.8% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and information on the practice website told patients how to access a number of support groups and organisations. The practice's computer system notified GPs if a patient was also a carer. This ensured that carers were not missed for regular health and well-being monitoring. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Families that had suffered bereavement were contacted by their usual GP when appropriate. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The practice engaged regularly with the clinical commissioning group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised locally.

The practice manager told us about their plans to continue making improvements including changes to the appointment and the open surgery provision to meet patient needs.

The practice had established a 'Care Home project' where GPs held a surgery once a month in selected care homes. The appointments for patients were pre-booked and their families are able to attend with them. They felt this provided a more holistic care model and reduced stress for the patient, their family and for care home staff. This service supported older people; people with long term conditions; people whose circumstances that make them vulnerable; and people experiencing poor mental health.

The practice manager also told us the practice was in the process of establishing a service for a local learning disabilities home. The GPs planned to provide a regular surgery at the home to reduce the stress for the learning disability patients, and the care staff.

The practice held a register of patients living in vulnerable circumstances including the homeless and those with a learning disability. The practice had committed to a Locally Enhanced Services (LES) to treat homeless people for the local area. A LES is a primary medical service locally agreed according to local demographic need other than a core essential GP contract service. The practice manager told us from the receptionists through to the GPs all staff members knew how to act, care, and treat patients in need of this service provision. The practice provided this service for patients in the Tendring area of the CCG.

The practice offered proactive, personalised care to meet the needs of the older people in its population and provided a range of enhanced services, for example, in 'remote care monitoring'. Remote care monitoring required the practice to; record appropriate patient preferences regarding how they want to receive their required test results, to maintain up to date contact details for the relevant patients, and have a system to register patients for remote care monitoring. 'Admission Avoidance' was another enhanced service which allowed older people at risk of hospital admission to call the surgery and speak to a GP the same day.

The practice had recognised the needs of different groups in the planning of its services. For example, the opportunity for longer and flexible appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises had been altered to meet the needs of patients with mobility difficulties. The consulting rooms were also accessible for patients with mobility difficulties. A portable induction hearing loop was available on request for patients benefit.

There were male and female GPs in the practice providing patients with choice.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. There was extended opening on two nights from 6.30pm to 7.30pm and one early morning from 7.30am to 9.00am. There was an open surgery (no need to book) between 10.30am until 11.30am Monday to Friday. We were told the practice monitored the patients' use of appointments and the open surgery provision, and adjusted it to meet patient requirements by providing additional staff at peak times. The practice had opted out of providing an 'out of hours' services which was provided by Care UK. Patients could also contact the NHS 111 service to obtain medical advice if necessary.

Comprehensive information was available to patients about appointments in the practice and on the practice website. This included how to arrange urgent appointments, home visits, how to book appointments and order repeat prescriptions through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number to ring depending on the circumstances.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse.

The patient survey information we reviewed published on 8 January 2015 showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 89.3% of patients who responded were satisfied with the practice's opening hours compared to the CCG average of 73.1% and national average of 75.7%.
- 93.7% of patients who responded described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73.8%.
- 62.7% of patients who responded said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 59.3% and national average of 65.2%.
- 90.9% of patients who responded said they could get through easily to the surgery by phone compared to the CCG average of 72.7% and national average of 74.4%.

Patients we spoke with were satisfied with the appointments system and said they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Comments received from patients, both those we spoke with and those made on comment cards also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints at the practice.

Patients we spoke with were not aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. We did note there was no access to information in the waiting room or reception area to support patients if they had a complaint. We looked at nine complaints received in the last 12 months and found these were satisfactorily handled, and dealt with in a timely way, with openness and transparency.

The practice reviewed complaints annually to detect themes or trends. We saw, lessons learned from individual complaints had been acted on and improvements made as a result. For example the appointment system was reviewed for patients arriving late for the open surgery.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the practice vision and values were part of the practice's statement of purpose and staff understood these values. The practice had business plans which reflected their vision and values.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on computers within the practice. We looked at 10 of these policies and procedures and all those we looked at had been reviewed annually and were up to date. The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example induction policy, and staff recruitment which were in place to support staff. Staff knew where to find human resource policies if required.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead for infection control and a lead for safeguarding. We spoke with members of staff and found they understood their own roles and responsibilities. Staff members told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the quality and outcomes framework to measure its performance. (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and acted on their findings.

The practice held monthly staff meetings where performance, quality and risks had been discussed and this was evident in minutes from meetings.

Leadership, openness and transparency

The GP partners in the practice displayed visible leadership and staff told us that they were approachable and took the time to listen to all members of staff. All staff were involved in discussions about the management of the practice and given the opportunity to express ideas for development. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We were shown agendas for meetings held weekly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at staff team meetings monthly, were confident in doing so and felt supported if they did. Staff told us they felt respected, valued and supported, particularly by the partners in the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the NHS' Friends and Family test', the annual GP practice survey, patient participation group meetings, and ad hoc surveys to understand specific aspects of practice service delivery. The responses from the 'Friends and Family' test show that all respondents were likely or very likely to recommend the practice. The practice actively encouraging patients to be involved in shaping the service delivered at the practice in the patient participation group meetings.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Innovation

Are services well-led?

Good

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

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw appraisals had taken place which included a personal development plan. Staff told us that the practice was very supportive of training to support their role development.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.