Brundall Medical Partnership

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?	Requires improvement
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 Brundall Medical Practice on 16 November 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- 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 said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, 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 a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements.

The areas where the provider should make improvements are:

- Ensure monitoring and auditing of fridge temperatures.

Summary of findings

- Improve the arrangements for the security of medicines stored in the dispensary to ensure they are only accessible to authorised staff.
- Ensure staff who undertake the checking of medicines in the dispensary are appropriately trained, qualified and competent to undertake this role.
- Ensure there are protocols in place for the handling, analysis, audit and review of dispensing errors including discussion at dispensing team meetings. In addition ensure near-miss dispensing errors are recorded so that trends of these errors can be monitored and actions taken where necessary.
- Ensure there are protocols in place for the monitoring and auditing of the risks involved in receiving telephone repeat prescription requests, ensuring processes for producing repeat prescriptions are undertaken away from avoidable distractions to prevent errors.
- Ensure that learning from concerns and complaints is shared and cascaded to all staff.
- Ensure patients waiting for their appointments in all areas of the practice can be clearly seen by reception staff to ensure patients whose health might deteriorate are not overlooked by staff.
- Ensure there is a programme of clinical audits undertaken in the practice, including completed clinical audit or quality improvement cycles.
- Ensure there is an audit trail to demonstrate which MHRA (Medicines & Healthcare products Regulatory Agency) alerts and safety updates had been implemented.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents. Incidents were reviewed by the GPs and practice management team and any lessons learnt were communicated to the team in order to support improvement.

The practice had established effective systems to manage and review safeguarding concerns including regular meetings with multidisciplinary teams. The appointment of new staff was supported by appropriate recruitment checks and all of the practice staff had received clearance from the Disclosure and Barring Service (DBS).

Internal assessments had been completed around the management of legionella and fire risks, issues identified had been actioned. We saw that not all patients waiting for their appointments in areas of the practice could be clearly seen by reception or other staff, there was a risk that patients whose health could deteriorate while waiting for their appointment, may be overlooked.

Robust arrangements for the security of medicines stored in the dispensary were not in place to ensure they were only accessible to authorised staff. Daily medicine refrigerator temperature checks were carried out which ensured medicines requiring refrigeration were stored at appropriate temperatures, however, some records were missing. Processes were in place to check medicines stored within the dispensary were within their expiry date and suitable for use, however, the practice did not keep records of this. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged and then reviewed promptly. However, we noted that the practice did not keep records of near-miss dispensing errors to help make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Procedures for dealing with medical emergencies were robust. Staffing levels were maintained to keep patients safe. Administrative systems were responsive and ensured that incoming correspondence was dealt with in a timely and effective manner and with full clinical oversight.

We found the practice to be visibly clean and patients told us that they had not encountered issues with cleanliness.

Summary of findings

Are services effective?

Good

The practice is rated as good for providing effective services.

Our findings on inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) and other locally agreed guidelines and that clinicians used these as part of their work. There was scope to provide further assurance around the effectiveness of care received by patients through clinical audit and review. The practice told us that they took this feedback on board.

Good health was promoted by the practice including self-management and a range of services including smoking cessation.

Staff had received training appropriate to their roles and any further training needs had been identified and planned to meet these needs. Appraisals and personal development plans were in place for all staff. Staff communicated effectively with multidisciplinary teams, and engaged in regular meetings with them to benefit care and enhance outcomes for patients.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained their confidentiality. Support was available at the practice and externally for those suffering bereavement or who had caring responsibilities for others.

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 NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy, and the partners and practice management team met

Summary of findings

frequently to focus upon key issues and business needs. Staff were clear about their own roles and responsibilities and how they contributed to the overall practice objectives. They spoke about their aim to be warm, helpful, friendly and accommodating to patient's needs. There was a clear leadership structure and staff felt supported by management through regular and effective communication. There was a high level of staff satisfaction and staff turnover was generally low. The practice worked with other local practices and engaged effectively with their CCG. The practice had a good range of policies and procedures to govern activity and held regular practice meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and influenced developments in the practice. All staff had received inductions, regular performance reviews and attended staff meetings.

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice provided medical support to a high number of patients in care and nursing homes compared to other local practices. The practice undertook weekly scheduled visits and was part of a clinical commissioning group (CCG) pilot to work with the local community matron to jointly work to reduce the number of unplanned hospital admissions while improving patient care. Practice nurses visited patients including housebound patients to provide flu vaccinations. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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 patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice provided space for the diabetic eye screening team three weeks per year. In addition a room was provided once a month for the diabetic nurse to see patients with more complex diabetic needs and the smoking cessation advisor provided a service once a week from the practice. The practice held Gold Standard Framework meetings to discuss those patients with a terminal prognosis and to ensure a multidisciplinary management review of their condition. Meetings involved a range of services including Social Services, palliative care nurses, community matron, physiotherapist and occupational therapists. GPs provided telephone numbers and weekend visits for those patients nearing the end of life.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances

and who were at risk. Immunisation rates were in line for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments with GPs and nurses were available outside of school hours and the premises were suitable for children and babies. Midwives and health visitors provided weekly clinics from the practice. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Patients we spoke with were positive about the services available to them and their families at the practice. Contraceptive services including contraceptive implant and coil fitting services were available weekly for patients; these were also available for patients from a neighbouring practice. One GP with a special interest provided monthly gynaecological clinics from the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of this group (including students) had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example following a patient complaint, asthma and smear appointments with the nurses were adjusted to ensure later appointments were available. Patients who requested a telephone call were contacted at the end of surgery by their GP; we were told this was popular with patients who needed to communicate with clinical staff but where an appointment was not required. The practice was proactive in offering online services as well as a full range of health promotion and screening at the practice which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances might make them vulnerable. Double appointment times were offered to patients who were vulnerable or with learning disabilities. Carers of those living in vulnerable circumstances were identified and offered support which included signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. Staff were aware of their responsibilities regarding information sharing,

documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. One nurse practitioner was responsible for learning disability reviews; we saw that 64% of patients with a learning disability had received a health check in the previous year. The practice held monthly multi-disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible community psychiatric nurses to discuss vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

The practice proactively identified patients who may be at risk of developing dementia. The practice were aware of the number of patients they had registered with dementia and additional support was offered. This included those with caring responsibilities. Practice nurses undertook dementia screening where appropriate at chronic disease reviews. The nurse practitioner undertook dementia reviews for patients who were unable to attend the practice. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. We saw that 76% of patients with a diagnosis of dementia had received a health check and review of their care plan in the previous 12 months (ending March 2015); this was an increase on the previous year's reviews of 64%.

The practice had told patients experiencing poor mental health about how to access various types of support and we saw information about this available in the reception area. Triage directed these patients for support quickly during periods of significant personal stress. The Norfolk Recovery Partnership (supporting patient with drug and alcohol issues), the Wellbeing Service Mental Health worker and the metal health counsellor visited the practice on a weekly basis to provide a service to patients. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

A register of patients experiencing poor mental health was being maintained and their condition regularly reviewed through the use of care plans. We saw that 93% of patients experiencing poor mental health had received a health check and review of their care plan in the previous 12 months (to the end of March 2015). Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations for provision of counselling and support.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 132 responses and a response rate of 51%.

- 91% find it easy to get through to this surgery by phone compared with a CCG average of 79% and a national average of 73%.
- 88% find the receptionists at this surgery helpful compared with a CCG average of 90% and a national average of 87%.
- 54% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62% and a national average of 60%.
- 88% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 94% say the last appointment they got was convenient compared with a CCG average of 95% and a national average of 92%.
- 77% describe their experience of making an appointment as good compared with a CCG average of 78% and a national average of 72%.
- 77% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 72% and a national average of 65%.
- 65% feel they don't normally have to wait too long to be seen compared with a CCG average of 65% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. All of the 21 CQC comment cards we received were very positive about the service experienced. There were only two negative comments which raised concerns about the difficulty in getting an appointment. Patients we spoke with told us they felt the practice offered a good service and that staff were helpful, compassionate and treated them in a respectful manner. However we were told there was a wait of two to three weeks to see their GP of choice. Patients told us they were satisfied with the care provided by the practice.

Areas for improvement

Action the service SHOULD take to improve

- Ensure monitoring and auditing of fridge temperatures.
- Improve the arrangements for the security of medicines stored in the dispensary to ensure they are only accessible to authorised staff.
- Ensure staff who undertake the checking of medicines in the dispensary are appropriately trained, qualified and competent to undertake this role.
- Ensure there are protocols in place for the handling, analysis, audit and review of dispensing errors including discussion at dispensing team meetings. In addition ensure near-miss dispensing errors are recorded so that trends of these errors can be monitored and actions taken where necessary.
- Ensure there are protocols in place for the monitoring and auditing of the risks involved in receiving telephone repeat prescription requests, ensuring processes for producing repeat prescriptions are undertaken away from avoidable distractions to prevent errors.
- Ensure that learning from concerns and complaints is shared and cascaded to all staff.
- Ensure patients waiting for their appointments in all areas of the practice can be clearly seen by reception staff to ensure patients whose health might deteriorate are not overlooked by staff.
- Ensure there is a programme of clinical audits undertaken in the practice, including completed clinical audit or quality improvement cycles.

Summary of findings

- Ensure there is an audit trail to demonstrate which MHRA (Medicines & Healthcare products Regulatory Agency) alerts and safety updates had been implemented.

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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 specialist adviser, a practice manager specialist adviser, a practice nurse specialist adviser and a pharmacist adviser.

Background to Brundall Medical Partnership

Brundall Medical Partnership provides general medical services Monday to Friday from 8.30am to 6.30pm.The practice provides general medical services to approximately 7,971 patients and is situated in Brundall, Norfolk. The purpose built premises was extended in 2009, provides good access with accessible toilets and car parking facilities, including spaces for those who are disabled.

The practice has a team of four GPs meeting patients' needs. All four GPs are partners meaning they hold managerial and financial responsibility for the practice. The practice employs two nurse practitioners, one nurse clinical lead, two practice nurses and two healthcare assistants. There is a practice business manager, a dispensary manager, four dispensers and a dispensary assistant. In addition there is an office reception manager, deputy reception manager and a team of medical administrators, secretaries, summarisers and receptionists.

Patients using the practice also have access to community staff including district nurses, smoking cessation support, occupational therapists, support workers, health visitors and midwives.

The practice is a teaching practice and offers on-site training for qualified doctors who are training to become GPs. In addition the practice hosts training for year four medical students from the University of East Anglia.

Outside of practice opening hours a service is provided by another health care provider, by patients dialling the national 111 service.

Why we carried out this inspection

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.

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?

Detailed findings

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
- 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)

The inspection team :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC's intelligent monitoring systems.
- Carried out an announced inspection visit on 16 November 2015.
- Spoke with staff and patients.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were entered onto the system and automatically treated as a significant event. The practice carried out an analysis of the significant events.

Safety alerts were cascaded to appropriate staff members. However the practice did not maintain an audit trail to demonstrate which MHRA (Medicines & Healthcare Products Regulatory Agency) alerts and safety updates had been implemented. The practice agreed that this system would be introduced.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that health care assistants would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring service check (DBS). (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). We saw that staff who acted as the chaperone, took responsibility for adding this information and a read code to the patients' medical records.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. However we noted there were waiting room areas in the practice that were not easily visible to staff. We saw that a patient whose health was deteriorating while in the waiting room, was not visible to busy staff. We discussed this with the practice GPs and practice manager who agreed they would be reviewing patient safety in this area.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. There were a variety of ways

available to patients to order their repeat prescriptions which included telephone requests to reception staff. However, the practice had not considered the risks associated with this method which included distracting the dispensary staff in their work. The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. However, we noted that the practice should undertake more audits of the quality of their dispensing service. Dispensing staffing levels were in line with DSQS guidance and the staff had completed appropriate training. However, dispensing staff told us that sometimes second checks of dispensed medicines were provided by staff who were not qualified dispensers. Dispensary staff had their competency annually reviewed; however, reviews did not include the assessment of their practices by observation. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. There were arrangements in place for the destruction of controlled drugs. Members of dispensing staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. We noted that the practice should make more robust arrangements for the security of medicines stored in the dispensary to ensure that they are only accessible to authorised staff. Daily medicine refrigerator temperature checks were carried out which ensured medicines requiring refrigeration were stored at appropriate temperatures, however, some records were missing because these had not been recorded. Processes were in place to check medicines stored within the dispensary were within their expiry date and suitable for use, however, the practice did not keep records of this. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged and then reviewed promptly. However, we noted that the practice did not keep records of near-miss dispensing errors to help make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

- Recruitment checks were carried out and the six files we reviewed showed that appropriate recruitment checks had been undertaken 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 (DBS).We noted that the practice did not have a copy of a DBS check for one of the GPs on file. However we were able to check with NHSE that this had been done and that the GP was registered on the performers' list.
- The practice had group indemnity cover for all the GPs and nursing staff.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place to ensure that enough staff were on duty.
- The practice ensured the Care Quality Commission were informed via the statutory notification process for any relevant untoward event.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 90.9% of the total number of points available, with 10.8% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/ 2015 showed;

- Performance for diabetes related indicators were worse in comparison to the CCG and national average. The practice achieved 80.2% of the diabetes points available, this was 13.5 percentage points below the CCG average and 9 percentage points below national average. We discussed this with the GPs who confirmed they were working hard to improve their acheivement for diabetic indicators.
- Performance for dementia, depression, epilepsy, heart failure, hypertension, learning disabilities, palliative care and peripheral arterial disease were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- The dementia diagnosis rate was below national average. The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months to March 2014 = 64% and for QOF March 2015 = 76.4%. The practice had a very high number of patients in care and nursing homes compared to local practices and confirmed that regular reviews for patients with very complex needs living in local nursing homes had proved difficult to achieve.

We looked at a number of patients on chronic disease registers and saw that 76% of patients on the dementia register had received a heath check in the previous 12 months and 93% of patients experiencing poor mental health had received a health check in the previous 12 months.

There was a protocol for repeat prescribing which was in line with national guidance. 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 hypertension and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the clinicians had oversight and a good understanding of best treatment for each patient's needs. The practice had taken part in local prescribing incentive schemes and had achieved a 25% reduction in antibiotic prescribing. The GPs attended monthly CCG prescribing meetings to ensure the practice achieved cost or quality based prescribing achievements.

We were shown a number of audits that had been completed. One completed audit included the practice's prescribing of methotrexate (a disease-modifying anti-rheumatic drugs (DMARDs) used to reduce pain, swelling and stiffness over a period of weeks or months by slowing down the disease and its effects on the joints). This audit had been undertaken over two cycles; however there was a significant difference in the data collected for the second cycle of the audit in comparison to the first cycle. This made it difficult to evidence where change or improvement could be evaluated.

We looked at a two cycle audit of cervical smear data which addressed the competency of the individual smear takers over a 12 month period to May 2015. We also looked at an audit to establish the number of patients appropriately attending the local accident and emergency unit (A&E) undertaken on 19 January 2015. This showed a high

Good

Are services effective?

(for example, treatment is effective)

proportion of patients attending A&E for dental problems. The practice planned to re-audit this in January 2016. However, there were a limited number of two cycle clinical audits evidencing change in systems and processes, or evidence of discussion at meetings or cascading of the learning from these. Therefore the practice could not demonstrate evidence of change or improvement in the practice.

There was scope to provide further assurance around the effectiveness of care received by patients through clinical audit and review. The practice told us that they took this feedback on board.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- 30 minute weekly mentor sessions were provided for each member of the nursing team. In addition new GPs were provided with a weekly mentor sessions for the first few months of their employment with the practice.
- The practice ensured that patients, who required a blood test prior to seeing their GP, were offered a phlebotomy appointment with either the healthcare assistant or the practice nurse at that time to prevent them having to re-schedule their GP appointment.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Regular clinics were held in practice rooms by a dietician, a diabetes facilitator, a smoking cessation advisor, mental health link workers and diabetic eye screening. In addition there was a intrauterine coils and contraceptive implants service at the practice which was also available for patients registered at other local practices.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Good

Are services effective?

(for example, treatment is effective)

Patients were then signposted to the relevant service. A dietician was available on the premises and smoking cessation advice was available from a local support group. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 78.85% which was below the national average of 81.88% There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98.5% to 98.6% and five year olds from 94.7% to 98.7%. Flu vaccination rates for the over 65s were 72.1%, and at risk groups 51.53%. These were also comparable to national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice offered proactive, personalised care to meet the needs of it's patients and had a range of enhanced services, for example, anti-coagulation testing, deep vein thrombosis monitoring, minor injury treatment, NHS health checks, immunisations, post-operative dressings and removal of stitches.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Throughout the inspection, we found that patient care and a genuine desire to do the best for patients was the primary focus of the practice team at all levels. This was integral to the practice team's everyday work.

We saw that members of staff were polite and helpful to patients both attending at the reception desk and on the telephone and people were treated with dignity and respect. If the reception team noticed patients were struggling with basic tasks, they ensured that clinicians were made aware so that individuals were appropriately assessed. Staff were able to move patients who wanted to talk about sensitive matters, or if they appeared distressed, into an area where they could maintain their confidentially.

All of the 21 CQC comment cards we received were very positive about the service experienced. There were only two negative comments which raised concerns about the difficulty in getting an appointment. Patients we spoke with told us they felt the practice offered a good service and that staff were helpful, compassionate and treated them in a respectful manner. They told us they were satisfied with the care provided by the practice.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was in line for its satisfaction scores on consultations with doctors and nurses. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 87% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 95% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 95% and national average of 90%.
- 88% patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 91% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room, in the new patient registration pack and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was a carer. There was a practice register of all patients who had been identified as carers. Written information was available for carers to ensure they understood the various avenues of support available to them.

The practice had access to a range of mental health services, which could provide additional support to patients when required. Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice hosted a number of

Good

Are services caring?

support services including a weekly clinic for the Wellbeing Service mental health worker, a weekly clinic for the mental health counsellor and the drug and alcohol support service.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation when required and/or by giving them advice on how to find a support service. We didn't speak with any patients who had suffered bereavement, however staff we spoke with confirmed this support was provided and we saw examples of thank you letters from patients and their families where support had been given.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice was part of a pilot service for joint visits from GPs and the community matron to support patients who were vulnerable or who lived in residential homes, to reduce their unplanned admission to hospitals. In addition the practice had worked with the CCG to reduce unnecessary pathology requesting. As a result of the work the practice had undertaken, since April 2015 to June 2015 the practice had succeeded in a 22% reduction in gamma glutamyl transferase (an indicator for liver damage and disease) and a 29% reduction in urine microbiology (a screening investigation for infection).

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- There were longer appointments available for people with more complex needs such as some older people or those with a learning disability.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative patients. Meetings were minuted and audited and data was referred to the local CCG.
- The practice worked closely with the medicines management team towards a prescribing incentive scheme (a scheme to support practices in the safe reduction of prescribing costs).
- Online appointment booking, prescription ordering and access to basic medical records was available for patients.
- The practice provided text message appointment reminders to patients who provided mobile phone numbers.
- Home visits were available for those patients who could not attend the practice.
- Urgent access appointments were available for children and those with serious medical conditions.
- The practice had facilities for patients using wheelchairs.
- GPs visited terminally ill patients at weekends in their own time.
- The nurse practitioner offered the same day appointments.
- The practice had a policy of seeing any patient who felt they needed to be seen on that day. We were told when there were no more appointments patients were offered a 'sit and wait' clinic.The patient was invited to attend the practice at a given time and the practice aimed to see them within an hour.
- The nursing team saw patients with minor injuries. They saw approximately 60 patients per quarter (these numbers relate to patients who sustained an injury within a previous 48 hours period).

Access to the service

The practice was open between 8:30am and 6:30pm Monday to Friday. Appointments with GPs were from 8:40am to 11:30am every morning and 3:30pm to 6pm daily. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 74% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 91% patients said they could get through easily to the surgery by phone compared to the CCG average of 79% and national average of 73%.
- 77% patients described their experience of making an appointment as good compared to the CCG average of 78% and national average of 73%.
- 77% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 72% and national average of 65%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. There was a designated responsible person who handled all complaints in the practice.

The policy explained how patients could make a complaint and included the timescales for their acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. For example, where patients were unable to make an asthma review appointment on-line after 4.30pm, the practice amended the nurse sessions to allow some late asthma and cervical smear test appointment after 4.30pm.

The learning from complaints was cascaded to staff at practice meetings; however from our discussions with staff we found that learning outcomes from compalints was not always shared with staff. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. We looked at complaints recorded in the last 24 months and saw that these had been dealt with in a timely manner. A summary of each complaint included, details of the investigation, the person responsible for the investigation, whether or not the complaint was upheld, and the actions and responses made. We saw that complaints had all been thoroughly investigated and the patient had been communicated with throughout the process.

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. The practice mission statement of 'our aim is your care' was understood and reflected by the behaviour of all the staff. The practice values included;

- To put patients first.
- To think like a patient, seeing the world through their eyes, understanding and anticipating their needs.
- To be accessible and approachable.
- To provide patients with a great service and to offer straightforward processes.
- To be clear about communication at a level patients can understand.
- To look to improve the way the practice worked, to provide good value for money for patients and the NHS.
- To be a general practice where patients feel comfortable to visit and feel safe in the knowledge they will be offered a good primary care service.

Throughout our visit we saw a consistent, kind and compassionate approach to patients that generally supported these values. The practice leadership team were aware of the importance of forward planning to ensure that the quality of the service they provided could continue to develop. The partners were committed to improving primary healthcare and recognised the value of training and staff development. It was evident from our interviews with the management team, the GPs and the staff that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that was patient centred and put patient outcomes first.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff.
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- The GPs were all supported to address their professional development needs for revalidation. Staff were supported through appraisals and continued professional development. The GPs had learnt from incidents and complaints.
- There was a comprehensive list of internal meetings that involved staff. Patients and procedures were discussed to improve outcomes and these were then shared with an equally comprehensive list of meetings with external stakeholders.
- There were policies and procedures for every aspect of practice business. These included both clinical and administrative areas. Staff we spoke with had a clear working knowledge of them and could access policies through the
- The management team had a comprehensive understanding of the performance of the practice.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions
- The practice had completed reviews of incidents, compliments and complaints. Records showed that regular clinical and non-clinical meetings were carried out as part of their quality improvement process to improve the service and patient care. There was a programme of regular internal audits, including health and safety, fire risk assessments and building risk assessments.

Nevertheless, there was scope to strengthen governance in the following area:

- There was scope to ensure that the practice had a comprehensive understanding of its own performance through a programme of continuous completed clinical audit cycles, to monitor quality and make improvements.
- In addition there was scope to improve the monitoring of safety and quality in the dispensary.

Are services well-led?

Good

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

Leadership, openness and transparency

The GPs in the practice had the experience, capacity and capability to run the practice and ensure high quality care. Weekly clinical and regular practice meetings focussed upon clinical issues, business needs, and reviewed significant events and complaints. The practice staff prioritised safe, high quality and compassionate care. Staff told us that the GPs were approachable and always took the time to listen to all members of staff.

Staff told us that regular team meetings were held, and that there was an open culture within the practice. They had the opportunity to raise any issues at team meetings and felt supported if they did. Staff said they felt respected, valued and supported. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through a patient participation group (PPG) meeting quarterly until early 2014. Since that time the practice had formed a virtual PPG and communicated with members through emails. The practice also gathered feedback through the NHS friends and family test, the NHS choices website, the NHS national patient survey and the DSQS patient survey and other patient surveys. For example patients were invited to feedback on blood thinning medicines monitoring service provided at the practice. We looked at the response to the 2014/2015 PPG and saw that as a result of patient feedback the on-line booking of appointments had improved. The September friends and family test showed 100% of patients who responded, would recommend the practice to friends or family.

The practice also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt empowered to give feedback or provide suggestions on how things could be improved with colleagues and management. Good work was acknowledged by the practice management. Employees spoke positively about their experience of working for the practice and there was a low turnover of staff with several members of staff working at the practice for over 26 years. All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and their training reqirements. For example we saw that following a skills review of the practice team, a practice nurse had received support to train as a nurse practitioner. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot scheme to improve outcomes for patients in the area. For example;

- The practice took part in a local pilot scheme for joint visits from GPs and the Community Matron to local Residential Homes to reduce unplanned hospital admissions for vulnerable patients.
- Each member of the nursing team received a 30 minute session with a mentor. In addition new GPs received a weekly session with a mentor for the first few months of their employment with the practice.
- GPs, if necessary and appropriate, would provide personal mobile telephone numbers and visit terminally patients in their own home or residential homes during weekends
- The practice was a training practice, teaching year four medical students from the University of East Anglia.
- One GP with a special interest provided monthly gynaecological clinics from the practice.
- Regular clinics were held in practice treatment rooms by a dietician, a diabetes facilitator, the smoking cessation advisor and mental health workers. The diabetic eye screening service was available to patients for three weeks each year.
- The practice provided an intrauterine coil fitting and contraceptive implant service for patients. In addition this service was available for patients from other neighbouring practices.