

School Lane Surgery

Quality Report

The Surgery
School Lane
Thetford
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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

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 11 November 2014 as part of our new comprehensive inspection programme.

The provider, Dr Hadley-Brown and partners, provides services from two locations; School Lane Surgery in School Lane, Thetford and Thetford Community Living Centre which is also in Thetford. Thetford Community Living Centre was not inspected as part of this inspection.

The overall rating for this practice is good. We found the practice was good in the safe, effective caring, responsive and well-led responsive domains. We found the practice provided good care to older patients, patients with long term conditions, patients in vulnerable circumstances, families, children and young patients, working age patients and patients experiencing poor mental health.

Our key findings were as follows:

- The practice has a system for reviewing and responding to safety alerts and significant events.

- Staff take account of changes in national guidance when planning patient care.
- Staff have access to training to update their skills.
- The practice has developed a template to assist staff in planning for and providing care to patients with dementia, which the local Clinical Care Commissioning Group has requested be shared with other practices in the area.
- The practice had a robust governance structure in place with designated lead and administrative staff for a range of areas, alongside a range of different meetings for staff.

We saw several areas of outstanding practice including:

- The practice has worked to support those patients who first language is not English through the provision of an interpreter three days a week, and a good awareness of the health needs of patients from the migrant community.

Summary of findings

- The practice developed a template for the review of patients with dementia which the Clinical Commissioning Group requested be shared with other practices in the area.

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

The provider should:

- The provider should take action to improve the take up of annual health checks by patients who have a learning disability.

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?

The practice is rated as good for safe. There were systems and processes in place for managing and responding to safety alerts. Staff learnt from any incidents and events that occurred in the practice and we found changes had been made as a result. Patients, staff and visitors were protected against the risk of health care associated infections. Arrangements were in place to manage emergencies. Staff understood their responsibilities to raise any concerns about patients who may be at risk. Staffing levels were appropriately managed and maintained.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed that overall patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely, to ensure care pathways reflected best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was also aware of patients' cultural backgrounds when assessing their needs. Staff understood the arrangements for gaining patient consent to treatment. Arrangements were in place to promote patient health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed that generally patients were satisfied with the care they received from the practice. We saw that the practice had taken steps to ensure information was accessible to patients, providing translation services to the Portuguese community. During our inspection we saw that staff treated patients with kindness and respect and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with partner agencies to secure improvements to services where these were identified. Although some patients said they had to wait a number of weeks to get an appointment, urgent appointments were available the same day. Children were offered same day appointments.

Good



Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available. When complaints were made the practice responded and identified any learning as a result.

Are services well-led?

The practice is rated as good for being well-led. Staff were engaged with developments at the practice, describing it as forward thinking and one in which development was supported and encouraged. Staff, though, were less able to clearly articulate the vision and strategy for the practice. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population. The practice employed a care co-ordinator whose role included the supporting older patients. Care plans were in place and reviews of older patients were carried out. Unplanned hospital admissions were followed up.

Good



People with long term conditions

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Arrangements were in place to ensure patients had a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the practice worked with relevant health and care professionals to support patients.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Same day appointments were available as were appointments outside of school hours. The premises were suitable for children and babies. We saw examples of joint working with midwives and health visitors.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice provided appointments into the early evening through its practice located a short distance from School Lane Surgery. The practice had responded to a Patient Participation Group survey in 2011/12 with the introduction of online booking for appointments. Health promotion and screening that reflected the needs for this age group was taking place.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a

Good



Summary of findings

register of patients living in vulnerable circumstances including those with a learning disability. Although the practice had a system for requesting patients with a learning disability to attend for an annual health check, the take up was relatively low, and should be improved.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies.

An interpreter worked at the practice three days a week, to assist those patients whose first language was Portuguese. They were also offered longer appointments.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice had systems in place to ensure older patients with dementia had a care plan and a follow up review. This included those who were housebound. The practice had lead clinical and administrative staff to support patients with dementia.

Patients experiencing poor mental health were invited to attend the practice for different physical health checks. Facilities were made available in the practice for use by other professionals supporting patients with mental health needs, for example the mental health link worker.

Good



Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We received four completed comment cards all of which were positive.

We spoke with seven patients during our inspection. The patients we spoke with told us that, overall, they found staff to be helpful, and were involved in decisions about their care. Some patients told us that they had to wait a

number, four or five, weeks to get an appointment with a GP, and that appointments can run, on occasion, up to 30 minutes late. Patients confirmed that they were aware of the facility of an interpreter if needed.

We spoke with a representative of the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. We were told that they felt listened to by the practice.

Areas for improvement

Action the service **SHOULD** take to improve

The provider should take action to improve the take up of annual health checks by patients who have a learning disability.

Outstanding practice

- The practice has worked to support those patients who first language is not English through the provision of an interpreter three days a week, and a good awareness of the health needs of patients from the migrant community.
- The practice developed a template for the review of patients with dementia which, the Clinical Commissioning Group requested be shared with other practices in the area.

School Lane 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 GP, second CQC inspector, and a practice manager.

Background to School Lane Surgery

School Lane Surgery, School Lane, Thetford provides services to patients living in Barnham, Brettenham, Croxton, Elveden, Euston, Kilverstone, Thetford and Rushford.

The practice is a partnership of six which includes five GPs and a non-clinical managing partner. One GP partner holds the role of senior partner within the practice. Of the five clinical GP partners four are male. In addition to the five partner GPs, two associate GPs, both female, are employed at the practice, as well as a nurse manager, a nurse practitioner, five practice nurses, two healthcare assistants, an emergency care practitioner and a trainee phlebotomist. The clinical team is supported by a team of fourteen administrators and receptionists, as well as a practice manager.

The practice is a training practice for those doctors wishing to train as GPs. There were two trainee GPs working at the practice at the time of our inspection.

The practice has a patient population of 11,500. In addition, patients from the provider's nearby practice, with a patient population of 3,000, may also use School Lane Surgery.

School Lane Surgery, School Lane, Thetford does not provide any services from a branch surgery. The provider

does, however, offer services from one other practice, at Thetford Community Living Centre. Thetford Community Living Centre is separately registered from School Lane Surgery. We were informed, during our inspection, that patients registered at School Lane Surgery may attend Thetford Community Living Centre for appointments. Similarly those patients registered at Thetford Community Living Centre may attend for appointments at School Lane Surgery.

The practice holds both General Medical Services and Primary Medical Services contracts to provide primary medical services.

The practice has opted out of providing out-of-hours services and these services are available from another provider. The practice website clearly details how patients may obtain services out-of-hours.

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.

Detailed findings

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 patients 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group (CCG) and the NHS England Local Area Team. The CCG and NHS England are both commissioners of local healthcare services.

We carried out an announced inspection on 11 November 2014.

During our inspection we spoke with a range of staff; reception, administrative and clinical staff. We also spoke with patients who used the service, and a representative of the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

We reviewed comment cards which we had left for patients and members of the public to share their views and experiences of the service. We also reviewed a range of different records held by the practice.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. We reviewed the practice log of significant events. The log included who was responsible for any actions required and a timeframe for completion. Any lessons learnt were documented. The practice had also begun, in October 2014, to share a quarterly report, giving a brief summary of significant events with the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

Staff were aware of their responsibilities and the system for reporting significant events, and we saw changes as a result of incidents arising. Staff attended regular meetings where the outcome of significant events and any learning was discussed. Learning from complaints was also discussed.

A system was also in place to ensure any national patient safety alerts were recorded and managed appropriately. Patient safety alerts were cascaded to staff once they had been seen by the nurse practitioner at the practice. The practice's clinical pharmacist was responsible for cascading prescribing alerts.

The staff we spoke with were aware of the need to report incidents to other relevant bodies.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred. Significant events, and complaints and compliments, were recorded and we were able to review these for the previous 14 months. Significant events were an agenda item on different meetings held at the practice for example the weekly meeting of the nursing team, and the fortnightly governance meetings. Staff were also provided with an overview of significant events at the quarterly meeting of all staff at the practice.

The records we saw showed that generally investigations were undertaken promptly. There was evidence that staff had learnt from incidents and that there were improvements in the service as a result of any investigations.

Staff we spoke with were able to provide us with examples of changes that had taken place as result of incidents that had occurred. For example the management of pathology results when a GP was on holiday.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. The GPs and nurses had attended safeguarding training appropriate to their role, and comprehensive records were kept to ensure training was kept up to date. All administrative and reception staff had completed level 1 children's safeguarding training. All administrative, reception and nursing staff had completed training in adult protection. There was evidence the majority of GPs had also attended adult protection training. Staff had also attended, in July 2014, domestic abuse training. There were procedures in place for both safeguarding children and safeguarding adults.

There was a lead GP, within the practice, for safeguarding and the staff we spoke with identified this GP as the person to whom they would report any concerns. The staff we spoke with were also aware of where to locate relevant policies.

A member of staff we spoke with described to us an occasion when they had had safeguarding concerns about a child who had failed to attend for appointments. They told us they had reported this to the lead GP for safeguarding and appropriate action was taken, resulting in a positive outcome. The lead GP and health visitor met monthly to discuss any child deemed to be 'at risk'. The clinical recording system at the practice identified any 'at risk' child as well as unborn babies who may be 'at risk'. One of the administrative team took the lead in ensuring any child 'at risk' was recorded on the practice's system.

The practice had a chaperone policy. This set out the role of a chaperone, and the names of the trained chaperone staff at the practice. The policy included a checklist for

Are services safe?

consultations involving intimate examinations, which included the action to take if a member of the clinical team felt one was needed. We were informed that for the most part examinations that required a chaperon were not immediate and a female GP could be provided. The staff we spoke with were able to describe their roles in chaperoning patients and the process; including the recording in patients' notes.

Records we saw showed that staff at the practice had been subject to criminal checks through the Disclosure and Barring Service.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw that medicines were kept at the required temperatures.

Although the fridges were not hard wired there were clear signs advising staff they must not be switched off. Records showed that the temperatures of the fridges were routinely taken and the temperatures were within the required temperature range.

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

The practice's clinical pharmacist undertook audits of medication prescribed, and monitored the impact of any changes arising out of these audits. We were told by a member of staff that the audits had resulted in changes in the medication prescribed. One recent audit on antibiotic prescribing led to the introduction of a patient leaflet with the aim helping patients better understand the use of antibiotics. We saw minutes of the practice's prescribing meeting where the clinical team discussed the outcome of any audits, any National Institute for Health and Care Excellence (NICE) guidance, and any relevant changes in medicines prescribed at the practice.

Repeat prescription requests were available on line and by post as well as in person. We discussed the arrangements with a member of the clinical team who explained that the checks on prescriptions were carried out electronically prior to signing any paper copies of prescriptions. The GPs were supported by one of the senior reception staff who took the lead in managing requests for repeat prescriptions.

Patient Group Directions were in place and up to date for the administration of vaccinations by the nurses. Patient Group Directions (PGDs) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.

Cleanliness and infection control

The practice had an infection control policy which included reference to related infection control policies and protocols such as the clinical waste protocol and hand hygiene policy. The nurse manager at the practice was the lead for infection control. An audit of infection control at the practice had been conducted by a company external to the organisation in 2014, and all concerns arising had been addressed. All staff working in the practice were trained in infection prevention control.

We found the premises were visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. The practice used a 'spot check cleaning template' to audit the cleaning at the practice regularly. There was a log for changing curtains in the consulting rooms in the practice; both disposable and non-disposable. A hand hygiene audit had been carried out in October 2014. Most staff passed the ultra violet test to check for hand hygiene at the time of this audit; some minor actions were required by some staff.

Staff we spoke with knew how to handle patients' specimens appropriately, and we saw a member of the reception staff receiving a patient's specimen correctly. Bags and gloves for staff use when handling specimens were available behind the reception.

We noted an uncovered sluice in a treatment room which staff said they did not use. The practice may wish to consider having a cover fitted to the sluice.

A register of the Hepatitis B status of both the nurses and GPs was in place.

A legionella risk assessment was in place and water temperature checks were carried out and recorded. Legionella is a germ found in the environment which can contaminate water systems in buildings.

Are services safe?

Equipment

Staff we spoke with told us about the routine calibration of equipment to ensure it provided accurate readings. We saw evidence of calibration of relevant equipment; for example weekly testing of the ketone meter used to monitor diabetes.

The practice had policies related to the testing of equipment and arrangements for portable appliance testing were in place. Annual portable appliance testing took place, by a contracted company, as well as the annual calibration of equipment in addition to the routine calibration carried out by staff at the practice

We were told that there is a lead member of staff responsible for ensuring equipment was kept in good working order. This included, ensuring repairs took place and any new equipment required was ordered.

Staffing and recruitment

The practice had a recruitment statement which set out a commitment to recruiting staff following the principles and ethos of the Equality Act 2010. The practice also had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We checked the records of three recently recruited staff. The records showed that staff were interviewed, and criminal records checks were carried out. Staff were provided with contracts of employment.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including the GPs, nursing and administrative staff, to cover each other's annual leave.

We saw an analysis, completed in July 2014, of the numbers and skills of nursing staff required at the practice and evidence of action taken as a result. This included the recruitment of a phlebotomist, and further training for one of the nurses.

Monitoring safety and responding to risk

The practice had a health and safety policy in place, which had last been reviewed in November 2014. The practice also had a lead member of staff for health and safety.

Health and safety checks were carried out. Any actions required were reported to the practices' governance meetings. Two members of the administrative team were the lead members of staff for health and safety, and were responsible for maintaining the related records. Fire, and health and safety training was provided to staff.

We saw that guidance on responding to emergencies was available to staff in the reception area. A member of staff we spoke with described that if a person waiting for an appointment was very unwell they would be asked to wait in the downstairs waiting room where they could be monitored by the reception staff. We were also told that in the event of an emergency one member of staff would undertake to coordinate the response. A GP would be called, the resuscitation equipment taken if needed, and an ambulance called if required.

A member of staff gave an example of the practice's response to a patient, who was not registered at the practice, who had arrived acutely unwell. We also saw a letter of thanking the practice staff for their 'quick response' to an emergency situation involving their child.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. On the day of our inspection staff were provided with update in training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). This emergency equipment was located adjacent to a door in the reception area which staff reported was central to all areas of the practice. There was a risk, however, that the emergency equipment was less easily accessible when the door was open. The practice manager said that this would be reviewed. We found the resuscitation equipment was checked weekly, and the defibrillator charged and the pads were in date.

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, failure of a supplier to deliver essential clinical supplies and access to the building. The document also contained relevant contact details for staff to refer to.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Different members of the clinical team were involved in national and local forums which helped ensure services were delivered in line with national best practice. One GP was a board member of the National Diabetes Society. Clinical staff have been involved in a range of care pathways in the Clinical Commissioning Group area. For example, GP input to the local diabetic pathway project, and nurse input in to a local respiratory pathway project.

The National Institute for Health and Care Excellence (NICE) guidance was available on the practice's computer. Members of the clinical and administrative team took a lead in different areas of care in line with the Quality and Outcomes Framework indicators. The Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care.

We were told that the clinical leads took responsibility for reviewing any NICE guidance for their respective area, updating any practice processes and cascading the relevant information. Another member of the clinical staff gave us an example of a change, following NICE guidance, in the template used by the clinical staff when assessing patients with diabetes.

The practice had lead administrative staff to ensure patients with long term conditions were supported. For example an administrator led on the diabetic eye screening, and another on regular reviews of housebound patients.

The practice operated a system of an on call GP each day; this GP undertook triage of patients and did not have planned patient appointments that day. They were also available to other GPs to discuss issues arising out of consultations. A member of the clinical team gave us an example of when they used the on call GP within the practice to check test results, if necessary; for example INR test results. The INR provides some information about a person's blood's tendency to clot (which is often described as how "thin" or "thick" their blood is).

The practice was aware of their patients' cultural background and any related disease trends; for example amongst their mainland European population groups.

Management, monitoring and improving outcomes for people

The practice had a system of monthly reporting on a range of areas that impacted on patient care. For example safeguarding, prescribing, the recall of patients for reviews of their care, and those patients aged 75 and over who were informed of their named GP. These monthly reports also included information that related to the Quality and Outcomes Framework for example the uptake of flu vaccinations. The QOF rewards practices for providing quality care and helps to fund further improvements. The information from these reports was collated by the administrative staff and reported to the relevant practice staff, to take any required action. The practice also held six weekly meetings to review their performance in relation to QOF and their enhanced services.

The practice showed us two completed clinical audits that had been undertaken in the last 12 months. The practice was able to demonstrate the changes resulting since the initial audits. For example the practice undertook an audit of the prescribing of a specific medication. On re-audit it was evident that improvements had taken place. The practice also provided evidence of audits that were underway, for example the use of antibiotics in patients who had a urinary tract infection.

From the evidence we reviewed we saw that audits took account of medicines management information and safety alerts. For example we saw an audit carried out following an alert issued by the Medicines and Healthcare products Regulatory Authority (MHRA) issued in respect of a prescribed medicine. The re-audit showed that the practice had reduced the number of patients prescribed this medicine in response to the MHRA alert.

Effective staffing

Practice staffing included medical, nursing, managerial, reception and administrative staff. We reviewed staff training records and saw that all staff were up to date with training identified as required by the provider such as annual basic life support. We noted a good skill mix among the GPs and nurses. Across the practice the GPs were qualified in a range of different specialisms including dermatology, substance misuse, and palliative care, with one GP specialising in diabetes. Within the team of nurses at the practice, qualifications were held in areas that included asthma, trauma care, wound care and diabetes.

Are services effective?

(for example, treatment is effective)

We found that two of the GPs had been revalidated and the remainder had a date for their revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council). We were informed that all appraisals were in date. A member of the administrative staff carried out a six monthly report on GPs to ensure they were on the General Medical Council register.

All staff undertook annual appraisals and a system was in place to ensure they took place. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the nurse team was trained in all long term conditions. One member of the team informed us they were due to start INR training in December 2014, and another that they had undertaken a diploma in COPD (Chronic obstructive pulmonary disease). INR provides information about a person's blood's tendency to clot. Weekly protected training time was in place for all staff.

The practice was a training practice, and the doctors who were training to be qualified as GPs were provided with a GP mentor in the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Information received from the out of hours 111 service each morning was allocated to the respective GP to review, but once attached to the patient notes was available to all staff. This allowed for another GP to review the notes in a colleague's absence. Patient test results were appropriately managed; they were scanned into the practice's system on the day of receipt and reviewed by the GP within 24 hours. The GPs would arrange to see the patient, if required, to discuss the outcome.

The practice employed a Care Co-ordinator who worked specifically with older patients. This included liaison with social care and any other relevant health care professional. There were links with the nearby care homes for older people.

The lead GP met regularly with the health visitor in respect of children at risk.

The practice provided rooms for diabetic eye screening, the community dietician, and for Norfolk young carers. Rooms

were also available for counsellors to see patients with mental health needs who didn't want to see their counsellor at home. The midwives were provided with access to the phlebotomy room to enable them to process blood samples for Thetford patients. The community drug and alcohol advisor was also provided with a room at the practice each week.

The practice had begun work with their Clinical Commissioning Group and another local practice on an urgent care project to improve access to urgent care. The practice has also worked locally with others to share good practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Any patient referred to the A&E department at the local hospital, for example, by the practice would be provided with a copy of their Summary Care Record to take with them. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

There were regular meetings, involving other different professionals, to discuss specific patients' needs. For example patients with end of life care needs, and children at risk.

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

Electronic systems were also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

Consent to care and treatment

The staff we spoke with had had training in and understood the requirements of the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. Additionally the staff we spoke with demonstrated an understanding of the importance of

Are services effective?

(for example, treatment is effective)

determining if a child was Gillick competent. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with described different ways of supporting patients to ensure they understood treatment options and to gain consent. This included language support for patients where this was required, and providing written information.

End of life care planning was in place at the practice. This enabled patients to give consent to their future care arrangements.

The practice had carried out an audit of patient consent to minor surgery. The practice found that there was no evidence of consent being recorded for three of 163 patients. We were informed that changes had taken place to the arrangements for recording consent as a result of this audit.

The National Patient Survey 2013 reported that the practice was in line with the national average for the proportion of respondents who stated that the last time they saw or spoke to a GP they were good or very good in involving them in decisions about their care. All but one patient with whom we spoke during our inspection confirmed with us that they gave their consent prior to any care and treatment. Family carers, with whom we spoke during our inspection, were confident that their GP was aware of any issues related to their relative's capacity to consent.

The practice was a GP training practice and, on their website, informed patients of their right to refuse to see a trainee GP.

The practice had guidelines and an in-house protocol in relation to restraint at the practice.

Health promotion and prevention

At the time of our inspection the practice did not offer a health check to all new patients registering with the practice. There were plans to introduce health checks for new patients in the new year; early 2015.

The practice provided a range of clinics including diet advice, blood pressure checks, diabetic checks, asthma

checks and smoking cessation, amongst others. Family planning services were also available. The practice website provided a range of health promotion information including information about support groups.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with a learning disability. Practice records showed 48% had received a check up in the last 12 months.

The practice also kept a register of patients with mental health needs. Practice records showed that of those for whom it was required 80% had attended the practice for a blood pressure check, 93% had had their lithium levels checked, and 63% had their alcohol consumption monitored.

The practice was in line with the national average for the percentage of patients who were smokers with health conditions whose notes contained an offer of smoking cessation support and treatment.

89% of women aged 25 and under 65 years had had a cervical smear test in the preceding five years. This was above the national average. The practice non-attenders were followed up by sending out three follow up letters, and a recall note was put on the patient's notes.

The practice did not offer sexual health checks for fifteen year olds, but contraceptive services were available for example condom advice. The practice did offer signposting to other services such as the Healthy Living Centre from which the provider also operated.

Chlamydia screening was carried out at the practice. Chlamydia screening kits were available in the waiting area, in consulting rooms and at reception for patients to take to use.

At the time of our inspection 93.4% of eligible patients under the age of 55 were offered appropriate contraceptive services as required.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations. There were two lead nurses for baby immunisations. For the first three months of 2014/15 the practice had had an uptake of 90%.

The practice kept a register of older patients identified as being at high risk of admission to hospital; approximately 231 patients. Follow up consultations were planned for

Are services effective?

(for example, treatment is effective)

older patients on discharge from hospital. All older patients who required extra support had a care plan and all were subject to review within the next three months. There were also structured annual medication reviews for polypharmacy. Polypharmacy is the use of multiple medications by a patient.

The practice was in line with the national average for the measures within the Quality and Outcomes Framework that reflected health promotion. For example the percentage of patients with diabetes who had an annual foot check.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, published in July 2014, which included responses from 184 patients, and a survey of 209 patients undertaken in 2013/14 by the practice's Patient Participation Group (PPG). The PPG is an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

Data from the national patient survey, published in July 2014, reported that 69% of patients surveyed felt that both their GP and nurses treated them with care and concern; the remainder reported that this did not apply to them or it was neither good nor poor. The PPG survey reported that the majority of patients felt they were treated with courtesy at the practice.

None of the patients surveyed, in the national patient survey July 2014, rated the nurses or GPs as either fairly or very poor in listening to them. Whilst none of the respondents reported that the GPs did not give them enough time, 5% felt that the nurses did not always give them enough time. The majority of patients said that they would recommend the practice to somebody new to the area; 5% reported that they probably would not recommend the practice. This was also reflected in the PPG survey when 199 patients reported that they were very satisfied or quite satisfied with the care at the practice; three patients, approximately 1%, reported that they were not satisfied.

Patients completed CQC comment cards to tell us what they thought about the practice. We received four completed cards and they were positive about the service provided.

We received comment from a patient we spoke with that they found the staff were helpful and polite, and felt their dignity and privacy were respected. Other patients we spoke with also said that they were generally happy with the staff at the practice.

The practice switchboard was located away from the reception desk, which helped keep patient information private. We saw staff handle information to promote confidentiality. We also saw that the reception staff we observed spoke with and treated patients with respect.

Care planning and involvement in decisions about care and treatment

The national patient survey information, of July 2014, showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 71% of the respondents reported the GP was either good or fairly good in involving them in care decisions. No patients reported that their GP was either poor or very poor in involving them in decisions about their care. None of the patients felt either the GP or nurse was poor in explaining treatment and test results to them.

We were told that older patients were involved in their care planning, as were their carers where appropriate. End of life care planning was in place, which reflected patients preferred place of care at the end of their life. We saw that the care plans used for patients with a learning disability and for those for patients with a mental health problem were comprehensive.

Although none of the staff employed at the practice could speak a second language staff had access to a folder detailing key questions in a range of different languages that they could use with patients who did not speak English.

Translation and interpretation services were available for patients who did not have English as a first language. The practice had responded to the needs of the population with a Portuguese translator at the practice three days a week. Patients were aware of when the translator attended and patients we spoke with during our inspection confirmed this. Information provided by the practice at the time of our inspection showed that the practice had the highest spend, in 2011/12, on face to face translation services compared to 25 other GP practices in their area.

Patient/carer support to cope emotionally with care and treatment

We saw evidence, during our inspection, of how well one family had been supported by the practice in caring for a patient at the end of their life. Staff we spoke with said that patients at the end of their life and their family were provided with whatever support they needed.

Are services caring?

The practice had a system of ensuring all staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient.

Information about support services was made available by the practice.

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 the needs of the practice population were understood. The practice was aware of the make-up of its patient population for example the transient nature of patients with approximately 150 new patient registrations a month. The practice population comprised approximately 25% foreign nationals. The practice responded through its use of translation services and undertook work with the Mobile Europeans Taking Action Group to provide patient signposting information. The practice was also aware of the prevalence of specific health issues amongst its population group for example thyroid related health needs.

The practice was working with a neighbouring practice and the Clinical Commissioning Group to improve access to urgent care for the population of Thetford. The practice has also hosted a number of pilot projects within the area for example, reviews of patients on oral nutrition products, and reviews of stoma care patients, this included making sure they had the right medication and products. This involved joint working with the stoma nurses and district nurses.

The practice co-ordinated the services it provided with its other surgery in Thetford, for example minor surgery, and patients were able to use the services at either surgery regardless of which practice they registered with.

There was a clinical lead for different areas of care, reflecting the Quality and Outcomes Framework (QOF). The Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care.

The Patient Participation Group (PPG) undertook patient surveys in the preceding two years. The PPG survey, in 2012/13, considered whether the practice should introduce telephone consultations. The result of this survey was that this was not required. In 2011/12 the PPG survey resulted in changes at the practice for example a new telephone system was purchased. Online appointment booking and repeat prescription requests were also introduced.

Tackling inequity and promoting equality

The practice provided information on their website in 20 community languages. The appointment check-in facility in the practice was set up to reflect the most common

languages in Thetford. A Portuguese translator was available at the practice three days a week to assist both administrative and clinical staff, and to translate documents. In addition staff had access to an interpretation and translation service.

An induction loop was provided at the practice for patients who were hard of hearing or deaf.

The premises were accessible to patients with physical disabilities for example a low reception desk and an accessible toilet. When necessary a note would be put on an appointment for a patient who wished to see their GP in a ground floor consulting room if the GP had an upstairs consulting room.

Patients who were homeless were able to use the practice's address to register as a temporary patient.

Equality and diversity training had been provided to staff, and was available on line.

Access to the service

From the national patient survey data of July 2014 the practice was in line with other practices in their Clinical Commissioning Group area for patients' ease of access in contacting the practice by telephone.

The practice was opened for appointments from 8:30am to 5pm Monday to Friday. Appointments for after 5pm were available for the practice population at the Healthy Living Centre. Although not a branch surgery of School Lane Surgery patients could attend the Healthy Living Centre, with the same staff and systems in place across both surgeries.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were arrangements to ensure patients received urgent medical assistance when the practice was closed. Home visits for housebound patients and those too unwell to attend the practice could be arranged by contacting the practice before 10.30am. The home visit was usually carried out between 12.30pm and 2.30pm each day.

Information about how to register with the practice was available on the practice website. In addition the practice

Are services responsive to people's needs?

(for example, to feedback?)

website provided information, in 20 community languages, about the role of the GP and how to register with a GP. Information about temporary registration as a patient at the practice was also available on the practice website.

Patients who were homeless were able to use the practice telephones to access the triage service. Travellers were able to register at the practice as patients unless registration as a temporary patient was more appropriate.

The practice clearly set out, on its website, services for which patients would be charged for example pre-employment medicals. Links were also provided to other services such as hospitals and dentists.

The practice secretaries provided support to older patients with their Choose and Book appointments. Choose and Book is a system enabling patients to choose the hospital or clinic they wish to use. There was a dedicated receptionist to manage any issues arising from the support provided to care homes including those for older patients. A GP visited the care homes on a weekly basis.

One of the administrative team led on reviews of those patients with long term conditions ensuring these took place.

The evidence we found regarding appointment availability was mixed. In the national patient survey, July 2014, 13% of patients said that they were either fairly or very dissatisfied with the opening times at the practice. Comments made by some patients in response to the PPG survey of 2013/14 also reflected that there were some concerns about the length of time to wait to get an appointment. On the day of our inspection the next available routine appointment was in fourteen days time. One patient we spoke with told us they had had to wait five weeks for an appointment and another told us that when they had originally been given an appointment it meant a four week wait. Two parents of children we spoke with told us that same day appointments were available for children.

Patients with a number of medical problems, a complicated medical condition or language difficulty were encouraged to book double appointments. However all the staff we spoke with said that patients would be given the length of time they needed to see a member of the clinical team, regardless.

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.

Details of how to make a complaint were available on the practice website. The practice had a complaints and comments procedure, and a senior administrator was the lead member of staff for co-ordinating complaints and responses to any received. The practice had a complaints leaflet advising patients how to complain. Patients we asked during our inspection said that they would know how to make a complaint, although one said that they would ask.

We looked at the complaints received since January 2014 and found whether these were satisfactorily handled, and dealt with in a timely way. The practice maintained a log of complaints which included details of any learning.

The complaints procedure was reviewed every three months as were all complaints. The practice reviewed complaints annually to detect themes or trends. The practice gave an example of a theme that had arisen and how this had been addressed.

We saw that complaints were discussed at the regular governance meeting in the practice.

There was evidence of changes in practice as a result of complaints received for example how staff were notified of the death of a patient.

Are services well-led?

(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 patient charter which set out the aims of the services; to provide the highest standards of healthcare to patients.

The staff we spoke with told us that they saw the practice as forward thinking and one that embraced change. However they were less able to articulate the vision or aims of the practice. This was despite a notice in the reception area setting out that the practice aimed to be safe, effective, caring, responsive and well-led.

The practice did not have a written, formal long term plan however the practice was succession planning for GPs, and developing inter practice liaison as part of its future planning, for example developing the urgent care pathway.

Governance arrangements

Policies and procedures at the practice were issued using a version control which recorded when the policy or procedure was written, and who wrote and approved it. There was evidence that the policies and procedures had been reviewed and updated giving the rationale for the update.

There was a clear structure in place with a range of different staff across the practice taking lead roles. This included both administrative and clinical staff. The different measures/indicators within the Quality and Outcomes Framework each had a clinical 'champion', a nurse lead and an administrative lead. The Quality and Outcomes Framework is a voluntary annual reward and incentive programme for all GP surgeries in England. The staff we spoke with were clear about their roles and responsibilities, and to whom they were accountable.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards.

The practice had an ongoing programme of clinical audits and regular system reporting on practice activity which it used to monitor quality and systems to identify where action should be taken. The patient charter also included

performance standards for example 80% of patients would be seen within 20 minutes of their appointment time. The practice used these standards to monitor their performance over the course of the day.

The practice held regular governance meetings. We saw that items for discussion included significant events, complaints and compliments, health and safety and training for example.

Leadership, openness and transparency

It was evident in our discussion with one of the partners that there was strong leadership at the practice. This was demonstrated in their vision for the practice and that the development of the practice was not dependent on their presence; that the practice should continue to develop regardless of the partnership arrangement.

The practice operated a system whereby there was a head of department for each of the different staff groups. Staff reported that they felt able to raise any issues or concerns for example, with the practice manager and lead nurse. A member of staff told us they felt listened to and any issues they raised were addressed. They told us they felt they were able to 'flourish' at the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a Patient Participation Group which met bi-monthly with the practice management and reception staff. A virtual Patient Reference Group (PRG) was also in existence. (The PPG and PRG are groups of patients registered with the practice who have no medical training but have an interest in the services provided. PPGs and PRGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.)

The practice viewed the virtual PRG as a means by which those who were house bound, and those who were deaf or hearing impaired could also actively contribute their views should they not wish or be able to attend the meetings. Annual reports for the PRG were available on the practice website. The report for 2013/14 included an update on the action plan arising out of the 2012/13 report, as well as an action plan for 2014/15. This included increasing the information available on the practice website, for example local pharmacy opening hours, which had been undertaken.

Are services well-led?

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

A member of the PPG we spoke with said that they had seen positive changes at the practice over the years. They said that they felt listened to by the practice.

Staff we spoke with said that they felt able to make suggestions for changes. We were given an example of a where the administrative time of a member of the clinical team had been increased following their request. They told us the lead nurse had considered the request and undertaken some staffing calculations leading to agreement with the request.

The practice had a whistleblowing policy, updated in 2014, which was available to all staff. Whistle blowing is when a former or current member of staff raises concerns about potential risk, malpractice or wrongdoing in their organisation. The whistle blowing policy also directed staff to other organisations from which they could seek help and advice if necessary.

Management lead through learning and improvement

Staff told us that the practice supported them through access to training. We reviewed three staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training and we were given examples of where training had been provided based on individual staff development needs, for example in carrying out staff appraisals. Reception staff had been provided with customer care training, as a way of improving patients contact with the practice.

Protected time for learning for all staff took place once a week.

The practice was a GP training practice and at the time of our inspection there were two GP registrars working at the practice. GP registrars are doctors who are training to be GPs.

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.