Newmarket Road Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Newmarket Road Surgery on 20 October 2015. The overall rating for this practice is good. Specifically, we found the practice to be good for providing safe, effective, caring and well led services. It was also good for being responsive.

It was good for providing services for the care experienced by older people, by people with long term conditions and by families, children and young people. Working age people, those in vulnerable circumstances and people experiencing poor mental health also received good care. Our key findings across all the areas we inspected were as follows:

- The practice was a friendly and caring practice that addressed patients' needs and it worked in partnership with other health and social care services to deliver individualised care.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- 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.
- 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.

We saw several areas of area of outstanding practice:

- The practice used dementia friendly signs and images throughout the premises.
- One of the GP partners, who was on long term sick, was present on the day of the inspection to spend time with our advisors and answer any questions we had. This reflected the care and interest this GP, and other staff invested in their practice.

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- Staff commented on good training and development opportunities and felt well supported by the GPs and management.

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

- Undertake regular fire drills.
- Carry out risk assessments to ensure a safe practice environment is maintained.
- Effectively record audit procedures for infection prevention and control.
- Improve complaint recording. When we reviewed the significant events we noticed that there were some incidents recorded that could have been logged as a complaint but weren't.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for most staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for all aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect.

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). Patients said they found it easy to make an appointment 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to

Summary of findings

deliver this vision was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG).

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 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 to avoid older people needing to use a taxi; in addition it offered home flu vaccinations or would pick up prescriptions for patients if these were urgently needed. On Mondays the practice had a dedicated GP for visits only so that there would be no outstanding visits after the morning surgery. The practice had 101 admission avoidance plans in place at the time of our inspection.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were in line or just below local averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies with toys available. Weekly ante-natal clinics were held by a visiting midwife and a private space for breastfeeding was available.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of

Summary of findings

care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Telephone consultations were available. Minor surgery was accessible at the practice avoiding the need to attend other healthcare locations. Flu clinics were also held on Saturdays.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. At the time of our inspection the practice had 15 patients on its learning disability register.

Performance for palliative care related QOF indicators was better at 100% than the national average of 97.6% and in line with the local average.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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 in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had 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. Staff received additional training on how to care for people with mental health needs and dementia. In the last 12 months prior to our inspection 30 out of 42 eligible patients had had their care plan reviewed.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing above local and national averages. There were 114 responses which represented a response rate of 45.2%. The results included:

- 87.4% would recommend this surgery to someone new to the area compared with a CCG average of 76.8% and a national average of 77.5%.
- 93.9% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 86.8% and a national average of 85.2%.
- 96.9% say the last appointment they got was convenient compared with a CCG average of 92.5% and a national average of 91.8%.
- 37.1% feel they don't normally have to wait too long to be seen compared with a CCG average of 57.8% and a national average of 57.7%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards, which were all very positive. One was positive about the standard of care received but mentioned the waiting times could extend occasionally, but the comment went on to explain that the GPs explained the reason for any delay. All the other cards contained comments around excellent care that was received and the caring and understanding nature of all staff.

Comments on the cards referring to the practice included terms such as “complete satisfaction”, “excellence”, ”prepared to go the extra mile” and “nothing but excellent courteous treatment”. In summary, there was a range of positive comments about the skills of the staff, the cleanliness of the practice, the treatment provided by the GPs and nurses and the way staff interacted with patients. There were no negative comment cards.

These findings were also reflected during our conversations with five patients during our inspection. The feedback from patients was overall extremely positive. Patients told us about the good care they felt they received and that where necessary they could get an appointment when it was convenient for them with a GP. Patients commented on the good relationships they had with their GP. Patients told us that staff made time for them and had good communication skills. Patients said they felt they were referred appropriately and timely. Patients commented about the different staff groups and their kindness at all levels. The patients we spoke with told us they felt their treatment was professional and effective and they were very happy with the service provided. Some commented that the extended opening hours were useful.

Areas for improvement

Action the service SHOULD take to improve

- Undertake regular fire drills.
- Carry out risk assessments to ensure a safe practice environment is maintained.
- Effectively record audit procedures for infection prevention and control.
- Improve complaint recording. When we reviewed the significant events we noticed that there were some incidents recorded that could have been logged as a complaint but weren’t.

Outstanding practice

- The practice used dementia friendly signs and images throughout the premises.

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- One of the GP partners, who was on long term sick, was present on the day of the inspection to spend time with our advisors and answer any questions we had. This reflected the care and interest this GP, and other staff, invested in their practice.
- Staff commented on good training and development opportunities and felt well supported by the GPs and management.
- Staff commented on ample training and development opportunities and felt well very well supported by the GPs and management.

Newmarket Road 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 specialist adviser and a practice manager specialist adviser.

Background to Newmarket Road Surgery

Newmarket Road Surgery provides general medical services to approximately 6000 patients living in the south of Norwich and the surrounding area. The population the practice serves consists of a higher percentage than average (against both local and national figures) of patients aged 45 and over and lower than averages for patients aged 44 and below.

The premises consist of a converted residential grade two listed building with treatment and consultation rooms on ground and first level. Limited parking is available with level access to the surgery. Entrance doors are automatic and spacious.

The practice has a team of four GPs, male and female, meeting patients' needs. These GPs are partners, meaning they hold managerial and financial responsibility for the practice. There are two practice nurses and one health care assistant, with an additional health care assistant being recruited at the time of our inspection.

There is a practice manager and an office manager with a team of six administrative, secretarial and reception staff who share a range of roles; two of the receptionists also work one morning a week each as phlebotomists in the surgery. The practice also hosts other services, for example community midwives run sessions weekly at the practice.

The practice provides a range of clinics and services, most of which are detailed in this report, and operates generally between the hours of 08:30 and 18:00, Monday to Friday. Appointments with GPs were from 08:50 to 12:30 and 16:00 to 18:00 every weekday, with late appointments until 19:30 on Monday. Nurse and health care assistant appointments were from 08:30 to 13:00 and 14:00 to 17:30 every weekday. Pre-bookable appointments could be booked up to seven weeks in advance with GPs and eight weeks in advance with nurses and health care assistants; urgent appointments were available for people that needed them.

Outside of these hours, medical care is provided by Integrated Care 24 Limited (IC24). Primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services 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 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 intelligent monitoring systems.
- Carried out an announced inspection visit on 20 October 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.

Good

Are services safe?

Our findings

Safe track record and learning

The practice had a policy and a significant event recording process which was accessible to all staff. There was an open and transparent approach and a system in place for reporting and recording significant events. Records and discussions with GPs identified that there was consistency in how significant events were recorded, analysed, reflected on and actions taken to improve the quality and safety of the service provided. There were eleven significant events recorded in 2014-2015 including, amongst others, a confidentiality issue and GPs not being informed of blood test results and prescription related matters.

Significant events were shared with the practice staff during meetings to support improvement of the service provided. The practice felt they could improve their significant event procedures and was in the process of implementing electronic tools to aid this review.

Safety was monitored using information from a range of sources, including National Patient Safety Alerts (NPSA) and the National Institute for Health and Care Excellence guidance (NICE - the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment). Alerts were disseminated to relevant staff electronically and a record was kept of the dissemination; this record reflected recent updates. This enabled staff to understand risks and gave a clear and accurate picture of safety. We spoke with several members of staff who confirmed the process took place and were able to give examples of recent updates. We found that alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) had been disseminated to all GPs and actioned. However we noted that two recent safety updates from MHRA (around Ibuprofen and Hydroxyzine) had not been addressed. To avoid this occurring in the future the GPs informed us they would subscribe individually to the MHRA safety update system immediately.

Staffing and recruitment

- 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 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 nursing and administrative staff, to cover each other's annual leave and sickness.
- Recruitment checks were carried out and the personnel files we reviewed showed that recruitment checks had been undertaken prior to staff's 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 found the practice had a low turnover of staff with the exception of recent change in the nursing team due to retirement and the upcoming retirement of one GP. We were informed the practice made occasional use of locum GPs. We saw evidence of the recruitment procedures the practice undertook for locums and that this was a safe and thorough process which ascertained locums were fit to work in the practice. The practice manager informed us the practice attempted to use the same locum GPs as much as possible. With the upcoming retirement of one of the GP partners the practice manager explained that there was ongoing discussion regarding the recruitment of a new partner. The practice manager provided an in-depth explanation of what the practice thought would work best for them and how they would implement this.

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 were in place 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 on a regular basis and when concerns were raised. We were shown evidence of active GP involvement in children's safeguarding scenarios, which included home visits. Staff demonstrated they understood their responsibilities and all had received training relevant to,

or above their role. The practice's computer system highlighted children and adults with safeguarding concerns. Protocols were clearly displayed so that all staff could refer to them if necessary.

- Notices were on display advising patients that chaperones were available, if required. Several members of the practice staff undertook this role and had received a disclosure and barring check (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).
- 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 practice. The practice manager kept health and safety risk assessments which highlighted risks that were premises and environment related but these were basic and did not include any ratings for likelihood and consequence. Improvements that were made as a result were recorded, for example additional signage to prevent doors being wedged open. The practice manager also informed us that regular visual checks took place and staff raised risk issues for attention but these were not always recorded.
- The practice did have up to date fire risk assessments but there was no evidence that regular fire drills were carried out. We were informed that going forward the practice would undertake these regularly.
- All electrical and clinical equipment was checked to ensure it was safe to use.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. There was a GP who was the infection prevention and control (IPC) clinical lead supported by a practice nurse who had undertaken additional training. There was a protocol in place and staff had received up to date generic IPC training. Cleaning was undertaken by an external company daily. Staff had access to personal protective equipment such as gloves and aprons. The nurses had cleaning schedules in place for the treatment rooms. The practice told us IPC audits were done but were not recorded historically; hence we saw no evidence that action had been taken in the past to address any improvements identified. We were shown evidence shortly after our inspection that an audit had been done. It contained areas covered as well as actions undertaken, for example hard toys were cleaned. The practice had risk assessments in place to monitor IPC related matters in the premises such as a legionella risk management and an asbestos risk assessment.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy team to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there was a system in place to monitor and track their use.
- Hepatitis B immunisation was provided to all staff and records were present in staff files providing evidence this was in place.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and the practice had a defibrillator and oxygen with adult and children's masks available. Emergency medicines were 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 business continuity plan in place for major incidents such as power failure or building damage. The plan highlighted significant risk and what actions staff should take in different scenarios. The plan included a listing of important documentation that would need ordering or retrieving in case of the premises being compromised. Several copies of the business continuity plan were held off site.

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.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF - is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. In 2014/2015 the practice achieved 96.4% of the total number of points available, which was above the national average of 93.5% and below the local average of 97.0%. The practice reported 7.9% exception reporting (below CCG and national average). Data from 2014/2015 showed:

- Performance for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypertension, learning disabilities, palliative care, peripheral arterial disease, rheumatoid arthritis and stroke and transient ischaemic attack were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- Performance for diabetes related indicators was better compared to the CCG and national average. With the practice achieving 91.9% of overall points available for this indicator, this was 3.3 percentage points above the CCG average and 2.7 percentage points above the national average. Specifically:
- Performance for chronic kidney disease related indicators was 96.9% which was 0.1 percentage points below CCG average and 2.2 percentage points above national average.
- Performance for mental health related indicators was 96.2% which was 1.0 percentage points below CCG average and 3.4 percentage points above national average.
- •Performance for osteoporosis related indicators was 66.7% which was 23.2 percentage points below CCG average and 14.7 percentage points below national average. The practice explained that the rationale behind this was historical inappropriate coding and follow ups by the services these patients were generally referred to. The practice advised us that they were creating an osteoporosis specific coding protocol as well as recording templates and would ensure closer liaison with other services. This was planned to be discussed in a clinical meeting in the practice.
- Performance for secondary prevention of coronary heart disease related indicators was 95.6% which was 2.0 percentage points below CCG average and 0.6 percentage points above national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. GPs and nursing staff were involved in clinical audits. Audits included second cycles (re-audit) but there was not always evidence that considerable improvements were made as a result demonstrating any significant improvement in patient care. There was no standardised approach as to how the audits were recorded. Examples of the audits included: the prevention and treatment of osteoporosis. Some improvement was found at re-audit and action had been taken to make even further improvement, for example there was 100% improvement in referring patients for physical therapy and some individual patients benefitted from improved prescribing. An audit was conducted to ensure appropriate blood monitoring for a particular drug. A repeat audit had not demonstrated improvement in monitoring but it was hoped that the installation of a new computer system would aid the recall system. Further audit was planned to take place the following year.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and information governance. During the inspection we spoke to a member of staff who confirmed induction took place and was delivered effectively. The practice manager explained that new staff went through a closely monitored probation period. Staff files we reviewed were all adequate.

Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included appraisals, staff meetings and facilitation and support for the revalidation of doctors. However, we found that staff had not received up to date training in the Mental Capacity Act 2005 but saw evidence that this had been considered but was postponed due to the installation of a new computer system. It was planned to be undertaken within weeks of our inspection. After the inspection we received confirmation this was the case. Staff we spoke with confirmed they received protected time for training equivalent to half a day per week. If practice demand was high and led to training and development having to be done in additional time, staff were paid overtime. The practice had recently introduced quarterly meetings for nurses (in addition to their monthly meetings) to focus on training and development covering topics such as drug monitoring and urine testing. The practice also held practice training meetings every two months covering topics such as fire training and dementia training.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

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 the 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 information on palliative care patients was discussed twice monthly in meetings that were attended by GPs, community matrons, district nurses, mental health workers and social 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. Systems were in place to ensure information regarding patients was shared with the appropriate members of staff. This included when people moved between services, including when they were referred, or after they were discharged from hospital. Individual clinical cases were analysed at informal meetings between clinicians. We saw evidence that multi-disciplinary team meetings took place on a regular basis and that care, planning and co-ordination of care, support for family and carers and care plans were routinely reviewed and updated.

Staff we spoke with told us the clinicians and management team were all very approachable and supportive and they were confident they could raise concerns regarding patients with them. We saw that this also took place during meetings and the minutes we reviewed confirmed that this happened.

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. However, we found that staff had not received training in the Mental Capacity Act 2005 but saw evidence that this topic had been discussed during a recent meeting and that training had been considered but was postponed due to the installation of a new computer system. It was planned to be undertaken within weeks of our inspection.

We saw that 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. We saw records that indicated meetings had taken place to discuss best interest matters for patients with learning disabilities.

Good

Are services effective?

(for example, treatment is effective)

Staff were aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse to all newly registered patients. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and opportunistic chlamydia screening.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.The practice's 2014-15 QOF performance for cervical screening related indicators was below the CCG and national averages. With the practice achieving 95%, this was 4.3 percentage points below the CCG average and 2.6 percentage points below the national average. A named nurse followed up patients that didn't attend screening via letter and telephone reminders.

Childhood immunisation rates for vaccinations given were slightly below the CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86.7% to 94.1% and five year olds from 83.8% to 94.3%. Flu vaccination rates for the over 65s were at 76.0% compared to the national figure of 73.2% and at risk groups 47.0% compared to the national figure of 52.3%.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice. The information available included information about services to support them to stop smoking, live a healthy lifestyle and manage their alcohol intake. Information for patients who were carers or who might be suffering domestic abuse was available and included contact information and access to support services.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Consultation rooms were situated on ground and first level and when registering for their appointment patients were asked whether they could manage stairs if this was not already known by staff. If a scenario presented where a patient could not use the stairs then the clinician would use a consultation room on ground level. Patients were collected from the waiting room in person by the attending clinician.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice's switchboard was located away from the reception desk, hence maintaining confidentiality and information private. A private room to discuss matters would always be available if requested. We saw that a significant event was raised when a GP had heard another member of staff discussing confidential information over the phone outside of surgery hours. Importance of confidentiality was re-iterated and staff training carried out as a result.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 36 comment cards, which were all very positive. One was positive about the standard of care received. All the other cards contained comments around excellent care that was received and the caring and understanding nature of all staff.

All of the 36 comment cards we received were very positive about the service experienced. Patients said they felt the practice offered a very good service and staff were professional, helpful, caring and treated them with dignity and respect. Comments on the cards included terms such as "complete satisfaction", "excellence", "prepared to go the extra mile" and "nothing but excellent courteous treatment". In summary, there was a range of positive comments about the skills of the staff, the cleanliness of the practice, the treatment provided by the GPs and nurses and the way staff interacted with patients. There were no negative comment cards but one card mentioned the waiting times could extend occasionally, but the comment went on to explain that the GPs explained the reason for any delay.

We spoke with five members of the patient participation group (PPG - this is a group of patients registered with the practice who have an interest in the service provided by the practice). They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. The members mentioned they could access appointments when required and felt they had good relationships with the GPs and other staff.

Results from the July 2015 national GP patient survey showed patients were very happy with how they were treated and that this was with compassion, dignity and respect. The practice performed consistently above average for all its satisfaction scores on consultations with doctors and nurses. For example:

- 90.9% said the GP was good at listening to them compared to the CCG average of 89.3% and national average of 88.6%.
- 90.9% said the GP gave them enough time compared to the CCG average of 88.6% and national average of 86.6%.
- 96.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 95.8% and national average of 95.2%.
- 90.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85.1%.
- 96.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 90.4%.

Good

Are services caring?

- 98.5% said the nurse gave them enough time compared to the CCG average of 91.1% and national average of 91.9%.

The practice had introduced the NHS Friends and Family test (FFT) as another way for patients to let them know how well they were doing. For example, 2015 FFT data available to us showed that:

- In May, from 10 responses, 100% recommended the practice compared to 88% nationally.
- In June, from 18 responses, 100% recommended the practice compared to 88% nationally.
- In July, from 48 responses, 98% recommended the practice compared to 89% nationally.

Dementia friendly notices, with text and pictures, were placed throughout the premises and informed patients of where to go, for example where the toilets were.

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 and the referrals made for them. 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 above local and national averages. For example:

- 90.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.
- 88.8% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81.9% and national average of 81.4%

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 and there was information available in multiple languages through the practice website.

Patient and carer support to cope emotionally with care and treatment

Information in the patient waiting rooms told patients how to access a number of support groups and organisations.The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and 106 patients on the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for organisations such as social services for support. 77 patients were identified as being cared for. Written information was available for carers to ensure they understood the various avenues of support available in the practice's waiting room and on their website.

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, two GPs sat on the local council of members for the clinical commissioning group (CCG).Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- The practice offered bookable late appointments on Monday, for all patients including working patients who could not attend during normal opening hours.
- Urgent access appointments were available for children and those with serious medical conditions.
- Appointments with GPs could be booked up to seven weeks in advance and with nurses eight weeks in advance.
- Extended appointments were available, to provide patients requiring so, the opportunity to discuss their health care needs. For example, there were longer appointments available for people with a learning disability.
- Translation services were available for patients who were not fluent in English.
- The practice used signs throughout the premises that were considered dementia friendly with text and images assisting patients. This provided a safer and less challenging environment for patients who benefitted from the signs. It also ensured all patients were clear of where they were and where to go when moving around the practice.
- Parking was available and included spaces for disabled patients with level access. Entrance doors were automatic with plenty of room for access and egress as well as parking for prams and wheelchairs. Disabled facilities were available.
- The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. For example, home visits were available for patients who were housebound because of illness or disability. We were informed that where possible GPs would actively visit patients at home if they were of poor mobility or the elderly to avoid them having to use a taxi; in addition it offered home flu vaccinations or would pick up prescriptions for patients if these were urgently needed.
- GPs at the practice had special interests in different clinical fields, including diabetes and prescribing.
- All registered patients had been allocated a named, accountable GP.
- There were baby changing facilities available.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative patients. This included the Gold Standard Framework working in which the practice was proactive.
- Online appointment booking, prescription ordering and access to basic medical records was available for patients.
- Telephone appointments were available.

Access to the service

The practice operated generally between the hours of 08.30 and 20.00 on Monday and between 08.30 and 18.00 Tuesday to Friday. Appointments with GPs were from 08.50 to 12.30 and 16.00 to 18.00 every weekday. With late appointments on Monday until 19.30. Appointments with nurses were from 08.30 to 13.00 and 14.00 to 17.30 every weekday. Appointments with GPs could be booked seven weeks in advance and with nurses or health care assistants eight weeks in advance. In addition to pre-bookable appointments that could be booked in advance, urgent appointments were also available for people that needed them.

People we spoke with on the day told us they were able to get appointments when they needed them. Of the 36 comment cards we received one card mentioned the waiting times could extend occasionally, but the comment went on to explain that the GPs explained the reason for any delay.

Results from the July 2015 national GP patient survey showed that patients' satisfaction with how they could access care and treatment was high in comparison to local and national averages. For example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 82.1% of patients were satisfied with the practice's opening hours compared to the CCG average of 75.3% and national average of 74.9%.
- 90.1% of patients said they could get through easily to the surgery by phone compared to the CCG average of 72.7% and national average of 73.3%.
- 88.6% of patients described their experience of making an appointment as good compared to the CCG average of 74.2% and national average of 73.3%.
- 43.8% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64.5% and national average of 64.8%. This was the only question where patients rated the practice below average. This score was in line with comments from the patients we spoke with on the day of our inspection who mentioned there could be a longer wait than expected sometimes. Most patients explained that they did not mind as they felt it was often the result of a highly personal consultation that sometimes required a longer appointment time. They said they would happily wait as they would receive a similar service.

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. A policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The dedicated person told us they liked to deal with complaints immediately. We looked at a log of complaints received in 2015. This included only one complaint, the previous year's summary consisted of four complaints. When we reviewed the significant events we noticed that there were some incidents recorded that could have been logged as a complaint but weren't. This indicated that there was room to improve complaint recording.

Records showed complaints had been dealt with in a timely way. 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.

We saw that information was available to help patients understand the complaints system for example information was available in the practice and on the practice website, summary leaflets were available.

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 vision to 'provide clinically safe and high quality care to all patients and to provide an effective and efficient range of GP services to patients'. Staff were clear about the vision and their responsibilities in relation to this.

There was a clear leadership structure and all staff we spoke with felt very well supported by management. Clinical staff felt very well supported in their decision making process.

Governance arrangements

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

- There was a clear staffing structure and planning and staff were aware of their own roles and responsibilities. Staff were multi-skilled and were able to cover each other's roles within their teams during leave or sickness.
- The practice used 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 supported to address their professional development needs for revalidation.
- There was planning in place to provide support to nurses in their revalidation, this was work in progress at the time of our inspection.
- Staff were supported through appraisals and continued professional development.
- Staff had learnt from incidents and complaints.
- There was a comprehensive list of internal meetings and training sessions that involved staff both in a formal and informal setting. Patients and procedures were discussed to improve outcomes.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and to identify and manage risk.
- GPs had undertaken clinical audits which were used to monitor quality and systems to identify where action should be taken and drive improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Although these were not rated.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The practice management team were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished. Staff told us that regular team meetings were held and there was an open culture within the practice. Staff said they had the opportunity to raise any issues impromptu or at team meetings, were confident in doing so and felt supported if they did.

The practice manager, in addition to their role in the practice, was elected to represent Norwich practice managers on the local medical committee for practice managers (LMC PM Forum). The practice manager had also chaired the local practice managers group for three years.

Different member of staff had lead roles on different subjects with the contingency that other members of staff could cover these lead roles when the usual lead was not absent. For example, one GP was the designated respiratory lead and attended annual updates together with the lead respiratory nurse. Another GP was the diabetic lead who also attended regular updates which they then shared with all relevant staff during practice meetings. We saw lists were displayed indicating a variety of roles and responsibilities for staff members. Staff commented this was helpful in case they needed assistance on a specific topic. The same principal was in place for QOF related topics.

Two GPs regularly attended local commissioning meetings.

We reviewed a number of policies, for example the whistleblowing policy, recruitment policy and chaperone policy which were in place to support staff and up to date. Staff we spoke with knew where to find these policies if required. It was clear from our interviews with the GPs, the

Are services well-led?

Good

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

management team and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first.

One of the GP partners, who was on long term sick, was present on the day of the inspection to spent time with our advisors and answer any questions we had. This proved useful for our questions but also commendable as it reflected the care and interest this GP, and other staff, had for the practice.The practice manager explained that they invited the external cleaners in to do their work during daytime hours so that they could feel part of the practice team. At the same time this also reduced risks to security and confidentiality by not having cleaners in outside of practice hours.

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

The practice encouraged and valued feedback from patients, proactively gaining their feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the website, patients' complaints and compliments. The practice had an active patient participation group (PPG). The group informed us the practice actively engaged with them and took their views and suggestions on board where possible, for example around the organisation of children's toys in the waiting rooms. The practice had undertaken a survey amongst patients in relation to the information screen in the waiting room in April 2015, changes were made as a result. We also saw that a survey was planned for November 2015 around patient knowledge of the Electronic Prescription Service.

The practice had introduced the NHS Friends and Family test (FFT) as another way for patients to let them know how well they were doing. For example, 2015 FFT data available to us showed that:

- In May, from 10 responses, 100% recommended the practice compared to 88% nationally.
- In June, from 18 responses, 100% recommended the practice compared to 88% nationally.
- In July, from 48 responses, 98% recommended the practice compared to 89% nationally.

Staff told us the GPs held regular away days, some of which were for all staff to attend. For example summer outings or Christmas gatherings. These were utilised to combine work based discussions with leisure time. The practice had also gathered feedback from staff through staff training days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they felt generally well supported and that communication within the practice was excellent. The reception team members explained that they felt their suggestions and feedback were taken in consideration. For example, headsets for the telephones were being introduced upon their request.

Management lead through learning and improvement

The practice had completed reviews of incidents, compliments and complaints. Records showed that regular clinical and non-clinical meetings and audits were carried out as part of their quality improvement process to improve the service and patient care. Audit cycles showed that some improvements had been made to improve the quality of the service and to ensure that patients received safe care and treatment. Some audits that had taken place were not yet part of a cycle of re-audit to ensure that any improvements identified had been maintained. The practice informed us that this would be addressed in the year after our inspection.

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. For example, two members of staff who worked in the reception/administration team also worked as a phlebotomist, one morning per week. The staff we spoke with felt very well supported and felt that their training needs were being met. The practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles. For example, one health care assistant told us the GPs and the practice manager actively encouraged professional development and made staff feel involved in clinical meetings. The practice had recently introduced quarterly meetings for nurses (in addition to their monthly meetings) to focus on training and development.

On Mondays the practice had a dedicated GP for visits only so that there would be no outstanding visits after the morning surgery. This allowed for all staff to attend the Monday weekly practice meetings

Are services well-led?

Good

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

Staff we spoke with confirmed they received protected time for training equivalent to half a day per week. If practice demand was high and led to training and development having to be done in additional time, staff were paid overtime. One of the GPs was active as a tutor to medical students, at the local University of East Anglia.

The practice had recently been approved as a training practice with one of the GPs being an associate trainer. It was planned that the practice would take on their first doctor student from April 2016.