Yare Valley Medical Practice

Quality Report

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Date of inspection visit: 6 October 2015
Date of publication: 10/12/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Yare Valley Medical Practice on 6 October 2015. Overall the practice is rated as good.

We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said there were urgent appointments available the same day and that there was continuity of care, however we were told it was not always easy to make an appointment with the GP of their choice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by the partners and business manager. The practice sought feedback from staff and patients, which it acted on.

We saw several area of outstanding practice:

Summary of findings

- The business manager had designed a template for patients with a diagnosis of dementia, this included amongst other things detailed patient identification, their next of kin contact information, legal representation information and health and medication information. This provided practice staff with instant access to any information required should the patients' health suddenly deteriorate.
- The business manager provided support for vulnerable patients to complete benefit and other claims forms both electronically and written.

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

Importantly the provider should;

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure that staff that undertake chaperone duties had received a disclosure and barring check (DBS) or had a written risk assessment completed.
- Ensure two cycles of a clinical audit are completed by GPs.

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 and addressed. Risks to patients were assessed and well managed.

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. Staff had received training appropriate to their roles, and had regular appraisals of their performance.

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 several 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, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able to make an appointment with a GP, with urgent appointments available the same day. However patients told us they were not always able to access an appointment with the GP of their choice. The practice had good facilities at both the main and the branch surgery with a planned move to a new purpose built surgery in 2016. Both sites were 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. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for the delivery of high quality care and staff were working towards achieving it. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular team meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and 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.

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 in line with national averages 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. The practice participated in regular meetings with the other health care providers, such as palliative care teams. The practice provided weekly 'ward rounds' to two local residential care homes, giving residents regular and consistent contact for non-urgent health issues.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments with GPs and nurses were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Patients we spoke with were positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

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 care. For example, the practice had introduced late evening extended hours appointments during the week and also on occasion Saturday morning appointments. 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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances might make them vulnerable. Double appointment times were offered to patients who were vulnerable or with learning disabilities. Carers of those living in vulnerable circumstances were identified and offered support which included signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice held monthly multi-disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible community psychiatric nurses to discuss vulnerable patients. The business manager provided support for vulnerable patients to complete benefit and other claims forms both electronically and written.

People experiencing poor mental health (including people with dementia)

Good

The practice proactively identified patients who may be at risk of developing dementia. The practice were aware of the number of patients they had registered with dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations such as the mental health charity MIND, Improving Access to Psychological Therapies (IAPT) and the community psychiatric

Summary of findings

nurse for provision of counselling and support. However not all staff had a clear understanding of the Mental Capacity Act and their role in implementing the Act. The business manager had designed a template for patients with a diagnosis of dementia, this included amongst other things detailed patient identification, their next of kin contact information, legal representation information and health and medication information. This provided practice staff with instant access to any information required should the patient health suddenly deteriorate.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 116 responses which represented a response rate of 38%.

- 77% find it easy to get through to this surgery by phone compared with a CCG and national average of 73%.
- 88% find the receptionists at this surgery helpful compared with a CCG and national average of 87%.
- 28% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 61% and a national average of 60%.
- 84% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 94% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 71% describe their experience of making an appointment as good compared with a CCG average of 74% and a national average of 73%.
- 69% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG and national average of 65%.
- 61% feel they don't normally have to wait too long to be seen compared with a CCG and national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were all positive about the standard of care received. However three cards commented on the difficulty of getting an appointment with their GP of choice. These findings were also reflected in the GP survey and during our conversations with patients during our inspection. We spoke with patients during our inspection and three representatives of the patient participation group. The feedback from patients was extremely positive. Patients told us they were able to speak to or see a GP on the day and where necessary get an appointment when it was convenient for them but not always with the GP of their choice. We were given clear examples of effective communication between the practice and other services. Patients told us they felt the staff were courteous and respected their privacy and dignity. In addition the GPs, nursing, reception and the management teams were all very approachable and supportive. We were told they felt confident in their care and liked the continuity of care they received at the practice. The patients we spoke with told us they felt their treatment was professional, effective and they were treated to the very best levels of care. We were told they were very happy with the service provided and felt they received loving care and consideration from the practice team.

Areas for improvement

Action the service SHOULD take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure that staff that undertake chaperone duties had received a disclosure and barring check (DBS) or had a written risk assessment completed.
- Ensure two cycles of a clinical audit are completed by GPs.

Outstanding practice

- The business manager had designed a template for patients with a diagnosis of dementia, this included amongst other things detailed patient identification, their next of kin contact information, legal representation information and health and medication information. This provided practice staff with instant access to any information required should the patients' health suddenly deteriorate.

Summary of findings

- The business manager provided support for vulnerable patients to complete benefit and other claims forms both electronically and written.

Yare Valley Medical Practice

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 Yare Valley Medical Practice

Yare Valley Medical Practice provides general medical services to approximately 7,507 patients. The practice area is mainly the Northeast or Broadland side of Norwich. The main surgery is on the Northeast side of the City of Norwich, less than a mile from Thorpe Road Railway Station. The branch Surgery is further north, on the Heartsease Estate. Approximately 70% of patients attend the main surgery with 30% attending the branch surgery. However patients were able to attend both practice sites.

Yare Valley Medical Practice was founded in 1944 and moved to the current site in 1972. The main practice was extended in 1990 and a purpose built branch surgery was opened in 1994. The practice is in the process of moving to a new purpose built surgery in 2016 which will combine both practice sites and include an on-site pharmacy along with the potential for other outreach services.

The current locations provide treatment and consultation rooms situated at ground level. Parking is available with level and ramp access and automatic doors. The practice is accredited as a training practice.

The practice has a team of four GPs meeting patients' needs. Two GPs are partners, meaning they hold managerial and financial responsibility for the practice.

There is a team of practice nurses, which include one advanced nurse practitioner, two practice nurse prescribers, two health care assistants and a phlebotomist who run a variety of appointments for long term conditions, minor illness and family health.

There is a business manager, an IT administrator and a team of non-clinical administrative, secretarial and reception staff who share a range of roles, some of whom are employed on flexible working arrangements. Community midwives run sessions twice weekly at the practice.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6pm, Monday to Friday. Extended hours appointments are available from 6.30pm to 8pm Tuesday and Wednesday evenings. In addition to pre-bookable appointments which can be booked up to four weeks in advance for nurses and two weeks for GPs, urgent appointments are also 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.

The practice continues to recruit to the GP partnership.

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.

Detailed findings

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

The inspection team :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC's intelligent monitoring systems.
- Carried out an announced inspection visit at both the main and the branch surgery on 6 October 2015.
- Spoke with staff and patients.
- Spoke with visiting health professionals.
- 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 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. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. These were located on the practice electronic system and staff demonstrated how to access them.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

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 (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. NICE is 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.

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 lead GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role. However not all staff that undertook chaperone duties had received a disclosure and barring check (DBS) or had a written risk assessment completed (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The business manager showed us they were in the process of undertaking DBS checks for every member of staff.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and fire drills had been undertaken. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The advanced nurse practitioner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- 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 teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the three files we reviewed showed that recruitment checks had been undertaken prior to employment. For example, proof of identification, and qualifications. However we found that not all references were written or that verbal

Good

Are services safe?

references had been recorded in staff records. Not all staff that undertook chaperone duties had received a disclosure and barring check (DBS) or had a written risk assessment completed. DBS checks were in place for all the GPs and nurses, however there was no DBS in place for the healthcare assistant and the nurses DBS checks were out of date. We saw the practice was in the process of undertaking new DBS checks for all staff including administration staff, which they anticipated would be completed by 30 November 2015.

- 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. Staff told us that following recent recruitments there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements, in particular the monitoring of clinical support during the previous year. For example the GP rota was planned three months in advance and the practice secured the use of established locum GPs in advance to ensure continuity of care for patients. There was a checklist protocol in place for when a locum GP was used, to ensure that appropriate checks and documentation was obtained.

Arrangements to deal with emergencies and major incidents

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

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. We were told that practice management and clinical meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) prescribing committee or quality standards from the National Institute for Health and Care Excellence (NICE) were assimilated during these discussions. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice. However during our inspection we were told that not all minutes had been typed up and circulated to staff. We discussed this with the business manager who told us these would be completed following our inspection.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. We saw the practice completed reviews of case notes for patients for example at risk of falls, with diabetes, asthma and hypertension to show they were on appropriate treatment and had received regular reviews of their health and medicine.

We found the practice monitored that guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 95.9% of the total number of points available, with 13.5% exception reporting. We discussed the practice high exception reporting with the GPs, we saw the practice supported 145 patients living at four local nursing/ residential and care homes. We saw that appropriate steps had been taken before patients were excepted from QOF indicators. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed;

- Performance for diabetes related indicators was below the CCG and national average. With the practice achieving 83.7% this was 4.9 percentage points below the CCG average and 5.5 percentage points below the national average.
- Performance for asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypertension, learning disabilities, mental health, osteoporosis, palliative care, rheumatoid arthritis and secondary prevention of chronic heart disease were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- The dementia diagnosis rate was below the national average.

We looked at a number of patients on chronic disease registers and saw that 40.5% of patients on the dementia register had received a heath check in the previous 12 months and 63% of patients on the depression register had received a health check in the previous 12 months.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the clinicians had oversight and a good

Good

Are services effective?

(for example, treatment is effective)

understanding of best treatment for each patient's needs. The practice had taken part in local prescribing incentive schemes achieving two of the three schemes proposed. The prescribing clerk and GP attended monthly CCG prescribing meetings to ensure the practice achieved cost or quality based prescribing achievements.

The practice recognised that due to the loss of four GPs and the difficulties the practice had encountered in recruiting GPs during the previous 12 months there had been a lack of clinical audit cycles. We were shown a number of audits that had been completed and some that were not written as a completed or planned audit. One completed audit included the practice's pregablin prescribing audit. This audit investigated the suitability of patients prescribed pregablin, a medicine used to relieve diabetic neuropathic pain for a replacement medicine, duloxetine.

Other audits included an audit of minor surgery data which addressed 16 questions in 2014 to 2015 however this was not written as a completed or planned audit. We also looked at an audit to establish the number of appointment lost to patients who did not attend for their appointment or DNA. However, only one of these was a clinical audit and had only been undertaken on one occasion, therefore the practice could not demonstrate that the changes implemented as a result of the first audit, had been successfully implemented. We discussed this with one partner and the business manager who described the practice plan to implement a regular rota of clinical and non-clinical audit in the future.

Effective staffing

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

- Practice staffing included medical, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training the practice regarded as mandatory such as basic life support, equality and diversity, moving and handling and health and safety.
- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. The practice business manager had developed a comprehensive induction pack and guide for locum GPs and nurses. This gave detailed guidance to all clinicians and staff on practice policies, staff contacts and how to access other services such as referral pathways and local hospitals.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. We were told that due to staff shortages appraisals had not always taken place, however we saw this had been addressed and all staff had received an appraisal in the previous 12 months. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- All GPs were up to date with their annual continuing professional development requirements and all either had 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).
- Due to the lack of GPs at the practice in the previous 12 months the prescription clerk had attended the prescribing incentive scheme meetings and reported back to the GPs. Since a lead prescribing GP was in place the prescribing clerk had continued to attend these meetings with the GP lead. We were told this had ensured the prescribing clerk had maintained their knowledge and understanding of current changes and guidance.

Coordinating patient care and information sharing

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

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they

Good

Are services effective?

(for example, treatment is effective)

are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

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

Health promotion and prevention

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

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81.11% which was comparable to the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69.4% to 95.9% and five year olds from 89.5% to 97.4%. Flu vaccination rates for the over 65s were 71.25% and at risk groups 39.85%. These were also below national averages. We discussed these rates with the business manager and were told due to recruitment issues the practice had struggled to encourage patients in the at risk group to attend for flu vaccines, however we were told since the practice had recruited further clinical staff they were on track for flu vaccinations for the current year.

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

The practice identified patients requiring additional support and offered signposting for patients, their families and carers to a range of organisations such as Help the Aged. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. Of the 38 patients on the learning disability register, 30 had received a health care review in the previous 12 months. Since 1 April 2015 to 30 September 2015 10 patients had received a health care review. These patients attended the practice for their annual review of their condition. Care plans in place were the subject of reviews.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 25 patient CQC comment cards we received were positive about the service experienced. Four, however, expressed concerns regarding access to appointments. The practice had undergone recruitment difficulties across GP and reception teams. We discussed this with the practice business manager and were shown how the practice had continually reviewed clinical cover to maximise appointment availability. We were told the practice anticipated their move to a new purpose built location in 2016 and the recent increase in recruitment would improve patient access. Patients generally said they felt the practice offered an efficient service and staff were helpful, caring and treated them with dignity and respect. Members of the patient participation group (PPG) we spoke with on the day of our inspection told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 84% said the GP was good at listening to them compared to the CCG and national average of 89%.
- 80% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 77% said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 88% 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%.
- 88% patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%.

The most recent friends and family test showed that 86% of those patients who responded to the survey would recommend the practice to a family member or friend.

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey we reviewed showed the practice was rated lower at 75% for respondents saying the GP was good at explaining tests and treatments in comparison to the CCG and national average of 86%. In addition 75% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.

Patients we spoke with on the day of our inspection told us that their health complaints were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt their children were dealt with in age appropriate way by the practice staff. Patient feedback on the comment cards we received was all positive around care received and aligned with these views.

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room 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 identified as carers and were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of

Good

Are services caring?

support available to them. The practice also ensured patients who were military veterans were identified and a read code added to their records to ensure they received additional support where required.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a telephone call or sympathy card. There were bereavement packs available for families This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. There was a notice board in the administration area which discreetly highlighted vulnerable or recently deceased patients. In addition there was an electronic alert on the computer system to ensure all staff were aware of the death and to avoid inappropriate communication. We heard how compassionate and kind the GPs and nurses were with regard to end of life care and how they had supported patients through bereavement.

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, an audit undertaken by the local CCG which looked at referrals to secondary care through the two week wait or urgent referral pathway, evidenced 100% of referrals made by the practice were appropriate for this pathway. The practice was aware of future challenges, under a Norfolk Clinical Commissioning Group local enhanced services contract, the practice provided support for 145 vulnerable patients across four local nursing/residential homes. The practice recognised the impact and increased demand from patients who required a high level of additional support. We were told the practice had liaised with the local CCG to ensure an even and safe distribution of patient services across the local area. The practice continually monitored the impact of these challenges on the provision of its service.

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 a 'Commuter's Clinic' on alternate Tuesday and Wednesday evenings from 6.30pm until 8pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability. In addition longer appointment were automatically booked for patients whose first language was not English and who needed translation services.
- Home visits were available for older patients / patients who would benefit from these.
- The practice nurse prescriber visited the frail and elderly in their homes.
- The practice offered a weekly 'ward round' to local care homes, providing regular contact and continuity of care for residents living there.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice was in the process of moving to new purpose built premises in 2016.
- There were disabled facilities, hearing loop and translation services available. In addition the practice acted as a recognised centre for the replacement of hearing aid batteries throughout the year.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative care patients. Meetings were minuted and audited and data was referred to the local CCG.
- The practice worked closely with the medicines management team towards a prescribing incentive scheme (a scheme to support practices in the safe reduction of prescribing costs).
- A diabetic nurse facilitator attended the practice one a month to work with the nursing staff and support patients with unstable diabetes.
- The practice business manager assisted vulnerable patients to complete benefit and claim forms when required.
- The practice provided a range of sexual health services including Chlamydia test and contraception. Appointments were available on a daily basis for patients who required emergency contraception or who had an acute problem.
- Baby immunisation appointments were available daily to provide easy access. The practice sends re-call letters to families which detailed the need for immunisation.
- Telephone consultations were available daily with GPs, practice nurses and the advanced nurse practitioner.
- Online appointment booking, prescription ordering and access to basic medical records were available for patients.
- The practice liaised closely with local pharmacies where prescription collection and delivery service were available.
- The advanced nurse practitioner provided minor illness services three days a week.
- A midwife provided services twice a week from the practice.
- The business manager had designed a template for patients with a diagnosis of dementia, this included amongst other things detailed patient identification, their next of kin information and health problems. This provided practice staff with instant access to any information required should the patient become frail or be at risk. The practice had piloted this at a local

Good

Are services responsive to people's needs?

(for example, to feedback?)

nursing/residential home and was planning to extend this to the other three homes they supported. In addition the practice planned to provide these for all vulnerable patients on their register.

Access to the service

The main practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am to 11.30am every morning with GPs and 12noon with the nurses. The practice opened again between 2.30pm to 5.30pm daily with GPs and1.30pm to 5.30pm with nurses. Extended hours surgeries were offered on alternate Tuesday and Wednesday evenings from 6.30pm to 8pm. In addition to pre-bookable appointments that could be booked up to four weeks in advance for a nurse and two weeks for a GP, urgent appointments were also available for people that needed them. Telephone consultations were available with GPs, the practice nurses and the advanced nurse practitioner. The branch surgery was open between 8am to 1pm and 2pm to 6pm on Mondays and 8am to 1pm Tuesday to Friday. The branch surgery was closed in the afternoons from Tuesday to Friday. We were told the practice also opened on Saturday mornings for pre-bookable appointments when demand required.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages. For example:

- 62% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 75%.
- 77% patients said they could get through easily to the surgery by phone compared to the CCG and national average of 73%.
- 71% patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 69% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 65%.

People we spoke to on the day of the inspection told us they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

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

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. We looked at seven complaints recorded in the last 12 months and saw that these had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice. For example, the practice had identified the need for staff to accurately record a current telephone number when a patient requested a call back.

A summary of each complaint included, details of the investigation, the person responsible for the investigation, whether or not the complaint was upheld, and the actions and responses made. We saw that complaints had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place to ensure learning as a result of complaints received was disseminated to staff.

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 work in partnership with its patients and staff to provide the best primary care services possible, working within local and national governance, guidance and regulations. The practice aims and objectives included to deliver high quality, safe, professional primary health care for its patients and to work in partnership with patients. To provide a learning organisation and to encourage patients to get involved in the practice. In addition the practice aimed to ensure all staff had the competence and motivation to deliver the required standard of care by ensuring all members of the team received the training and skills to carry out their duties competently. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews and listening to staff and patients. The practice had business plans which reflected their vision and values.

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

We found that practice staff were aware of future challenges including the imminent move of both the main and branch surgery to new premises. The business manager ensured patients were informed of future developments and changes with floor plans prominently displayed in the waiting area and floor plans and photographs available to view on the practice website and through the practice newsletter. The business manager and team had worked to drive the development and move to new premises in 2016. We saw the new premises had the capacity for 13 consulting rooms, a minor operations and treatment room with space for staff, clinical training, car parking facilities and room for future further expansion.

We found the practice was supported in its vision by a motivated business manager who together with one of the GP partners had a clear vision for the future in the new build and had shown that recruitment was likely to be resolved having received applications for new GPs.

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:

- The practice had a definitive vision for the way forward and a business plan to support this.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- The GPs were all supported to address their professional development needs for revalidation. Staff were supported through appraisals and continued professional development. The GPs had learnt from incidents and complaints.
- There was a comprehensive list of internal meetings that involved staff. Patients and procedures were discussed to improve outcomes and these were then shared with an equally comprehensive list of meetings with external stakeholders.
- There were policies and procedures for every aspect of practice business. These included both clinical and administrative areas. Staff we spoke with had a clear working knowledge of them. Practice specific policies were implemented and were available to all staff through the practice intranet.
- The business manager had a comprehensive understanding of the performance of the practice.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions
- The practice had completed reviews of incidents, compliments and complaints. Records showed that regular clinical and non-clinical meetings were carried

Are services well-led?

Good

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

out as part of their quality improvement process to improve the service and patient care. However as referred to earlier in this report there was a lack of clinical audit cycles to evidence that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment..

Leadership, openness and transparency

Staff told us the GP partners were visible in the practice and were approachable. We were told the business manager and GP partner took the time to listen to members of staff. We were told staff were involved in discussions about how to run the practice within their own areas and how to develop the practice: staff told us one GP partner and the business manager encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that regular meetings were held, including monthly practice meetings, monthly training meetings and monthly multi-disciplinary meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported. During our inspection we were told the senior partner would be retiring and was in the process of handing over to the second GP partner. We were told this partner had been supported and mentored by a third GP who had joined the practice as a salaried GP.

Due to previous GP retirement and resignations the practice had lost four GPs and administration/reception staff since 2014. This had forced an increase and amendment of workload on the remaining partners and staff. One GP partner told us that these recent setbacks posed a considerable challenge to the day to day running of the practice. The GP and the business manager told us that existing staff had shown dedication and commitment to ensure the safe and effective running of the practice. Staff told us that newly recruited additional staff had helped put the practice back on track.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys, met with patients at the surgery and submitted proposals for improvements to the practice management team. For example following the March 2015 patient participation group survey the PPG identified three priorities for action to improve patient satisfaction.

1. Improve access to GP appointments.
2. Improve continuity of GPs/GP retention.
3. Improve did not attend for appointment or DNA statistics.

We looked at the practice on-going action plan which included actions required a timeframe for actions to be put in place and completed comments and achievements. The most recent Friends and Family test showed 86% of patients who responded, would recommend the practice to friends or family. The practice produced a quarterly information leaflet and newsletter to inform patients of the latest news from the practice and any recent changes and actions from PPG meetings. This was available through the practice website.

The practice also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. We saw evidence of a staff training needs analysis that ensure all staff training requirements were addressed. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

Innovation

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. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed. There was a strong focus on continuous learning and improvement at all levels within the practice. Clinicians had areas of special clinical interest, for example, one GP had a special interest in mental health and

Are services well-led?

Good

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

psychology, the practice nurse prescribers had a specialist interest in chronic disease management such as diabetes, respiratory diseases. The advanced nurse practitioner had an interest in minor illness and provided a minor illness service at the practice three days a week. One healthcare assistant had undergone diabetic foot screening training and as a result was able to provide foot checks for diabetic patients. The practice was accredited to provide training for medical students which included foundation year doctors and specialist or general practice training doctors who were training to be qualified as GPs.

The business manager had designed a template for patients with a diagnosis of dementia, this included amongst other things detailed patient identification, their next of kin contact information, legal representation information and health and medication information. This provided practice staff with instant access to any information required should the patients' health suddenly deteriorate. The business manager provided support for vulnerable patients and those whose first language was not English to complete benefit and other claims forms both electronically and written.