Magdalen Medical Practice

Quality Report

Lawson Rd, Norwich, Norfolk, NR3 4LF
Tel: 01603 475555
Website: www.magdalenmedical.nhs.

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Magdalen Medical Centre on 13 October 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, and addressed.
- The partners were committed to improving primary healthcare and recognised the value of research, and regularly participated in a range of studies and research initiatives.
- Risks to patients were assessed and well managed. However fire drill were not regularly practiced by staff.
- Chronic diseases were managed by well-qualified and experienced nurses who followed guidelines.
- Patients said they were treated with empathy and respect and were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients.
- Improvement was needed to strengthen prescription pad security and to ensure that all prescriptions were signed for by the receiving pharmacies.
- Improvement was needed to strengthen recruitment procedures and ensure that all pre-employment information was obtained by the practice.

We saw several area of outstanding practice:

Summary of findings

- One of the GPs had trained as a breast feeding counsellor and provided voluntary breast feeding counselling at the local hospital and children's centre.
- One of the GPs regularly offered health promotion advice on radio Norwich.

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

Importantly the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff.

Importantly the provider should:

- Ensure that blank prescription forms are tracked through the practice in accordance with national guidance.
- Ensure that staff regularly undertake fire drills so that they are aware of what to do in in the event of an emergency
- Confirm the immunisation status for all clinicians.
- Ensure that repeat prescriptions are signed for when received by pharmacies.
- Ensure that clinical audit cycles are completed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents 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 managed. However the practices' recruitment procedures were not robust and staff did not regularly practice fire drills to ensure they knew what to do in the event of an emergency. The practice did not have a record of staff's immunisation status to ensure that they both, and their patients were protected.

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 in a way that they liked by staff, and that they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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 on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. The practice participated in regular meetings with the Integrated Care Organisation that was also attended by Age UK representatives. 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. Patients had structured annual reviews to check that their health and medication needs were being met. For those people with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. 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. The practice carried out seasonal flu immunisation, and shingles and pneumococcal vaccination for those at risk.

A visiting health trainer attended the practice every Monday to support patients in managing their smoking, alcohol intake and weight. Patients also benefited from a visiting heart failure and specialist diabetic nurse.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the practice's flexible appointment system allowed same day appointments for children with acute needs. Community midwives held twice-weekly clinics at the practice for antenatal appointments. Quarterly meetings were held with health visitors to discuss any children at risk.

The practice offered a full range of family planning services including intrauterine contraception. One GP had trained as a breast-feeding counsellor and was able to offer additional support to pregnant women and new mothers.

Summary of findings

The practice supported a local independent school and offered advice, signposting and training on a range of physical and mental health issues to pupils. All young people aged between 18- 25 years were offered chlamydia screening.

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Appointments were available from 8 am-6-pm each day.

Two physiotherapists were based at the practice which allowed easy access to get working aged people back to work quickly and provide advice on work related issues. The practice also participated in a 'telederm' service which allowed a consultant dermatologist to review skin lesions remotely, reducing the need for patients to take time off work for hospital appointments.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances might make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with complex needs and learning disabilities. It had carried out annual health checks for 57% of people with a learning disability on its list in the year 2014-2015.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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 A number of staff had received training in recognising and supporting patients affected by domestic violence.

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 kept a register of all those with significant mental health problems and 91% of people experiencing poor mental health had an agreed care plan in place.

Summary of findings

The Norfolk Recovery Partnership (drug and alcohol treatment team) used one of the practice's treatment rooms so that the patients did not have to travel to receive its services.

The practice kept a register of all patients living with dementia and offered them annual physical and mental health reviews. Practice staff had received training to become a dementia friendly practice. The GPs who provided services to local care homes had developed additional skills and knowledge in supporting those patients who lacked capacity to make decisions for themselves, and those whose liberty was deprived.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was overall performing slightly above local and national averages. There were 111 responses and a response rate of 41%.

- 81% find it easy to get through to this surgery by phone compared with a CCG average of 73 % and a national average of 73%.
- 89% find the receptionists at this surgery helpful compared with a CCG average of 87% and a national average of 87%.
- 83% 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%.
- 85% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 77% describe their experience of making an appointment as good compared with a CCG average of 72% and a national average of 73%.
- 65% feel they don't normally have to wait too long to be seen compared with a CCG average of 58% and a national average of 58%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards that were all positive about the standard of care received. Patients particularly valued the ability to see the same GP for their appointments, the attentiveness and professionalism of staff, the availability of same day appointments and the cleanliness of the premises.

We spoke with the managers of two residential care homes that the practice supported. They told us that they received an excellent service from the practice's GPs who visited the homes weekly.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.

Action the service SHOULD take to improve

- Ensure that blank prescription forms are tracked through the practice in accordance with national guidance.
- Ensure that staff regularly undertake fire drills so that they are aware of what to do in in the event of an emergency
- Confirm the immunisation status for all clinicians.
- Ensure that repeat prescriptions are signed for when received by pharmacies.
- Ensure that clinical audit cycles are completed.

Outstanding practice

- One of the GPs had trained as a breast feeding counsellor and provided voluntary breast feeding counselling at the local hospital and children's centre.
- One of the GPs regularly offered health promotion advice on radio Norwich.

Magdalen Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and included a GP specialist adviser and a practice manager specialist adviser.

Background to Magdalen Medical Practice

Magdalen Medical Centre is a well-established GP surgery that has operated in the area for many years. It serves approximately 13,198 registered patients and has a general medical services contract with NHS Norwich Clinical Commissioning Group. It is the biggest single site practice in Norwich and is located in an area of average deprivation. Compared with other practices nationally, it has a higher proportion of patients aged between 60 and 85 years and a lower proportion of patients aged between 5 and 19 years.

The practice consists of eight GP partners, one nurse practitioner, three nurses and three health care assistants. A number of reception and administrative staff support them. It is a training practice involved with the training of GPs.

The practice is open between 8am-1pm, and between 2pm- 6pm Monday to Friday. Appointments are available between 8am and 12noon, and between 2pm and 6pm

Why we carried out this inspection

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

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)

Detailed findings

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 October 2015. During our visit we spoke with a range of staff including GPs, nurses and administration staff. We also spoke with patients who used the service. We reviewed a small sample of treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

The practice had a robust system for recording significant events and had been recording these for many years. All staff we spoke with were aware of the procedure and told us they felt confident about reporting incidents. For example, one of the practice's reception staff told us she had recently reported an incident when she had confused two patients with the same name.

All significant events were recorded on the practice's intranet and available to staff for access. We viewed recent significant event forms and saw they had been completed in depth, with any action taken in respect of these events clearly recorded.

Significant events were discussed on the first and third Friday of every month at the practice's meeting. The practice manager told us that significant events used to be discussed at the end of these meetings which sometime limited their discussion time. In response to this, significant events now alternated between the start and end of each meeting to ensure they were given enough time. We saw evidence of this on the practice minutes we viewed for June and July 2015.

One practice meeting about every three months was dedicated to reviewing all significant events to ensure that any changes required had been implemented. Staff were able to give us specific examples where changes had been actioned as a result. For example, a patient had returned for the removal of a contraceptive device which could not be found at the consultation or ultrasound. The practice had amended their protocol in light of this and now both the patient and the GP checked the device was present some weeks after its insertion.

Significant events were also discussed at the quarterly administrative meetings. We viewed meeting minutes for 27 August 2015, where the importance of recording all significant events, both positive and negative, had been discussed at length with those present. Examples of recent significant events had been shared, along with the action needed to be taken to avoid their reoccurrence.

National patient safety alerts were disseminated to appropriate staff. Any relating specifically to medicines were actioned by the practice's prescribing lead, who arranged searches to be completed. A list of relevant patients was given to their specific GP to implement any changes required.

Reliable safety systems and processes including safeguarding

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. Training files we viewed showed that staff had received safeguarding training relevant to their role. In addition to this, many of the practice's staff (both clinical and administrative) had received training in recognising and supporting those affected by domestic violence.

There was a lead GP within the practice for safeguarding who regularly attended clinical commissioning group (CCG) led safeguarding meetings with leads from other practices. There were also regular meetings with the health visitor to review any children and young people on the practice's safeguarding list. Children with any safeguarding concerns were highlighted on the practice's computer system. Staff were able to give us specific examples of when they had reported safeguarding concerns.

The practice had undertaken a recent audit to check that a record was made of any adult accompanying a child to a consultation. This audit had revealed that only 52% of patents' notes for children contained a record of who had accompanied them. This was to be re-audited again, but preliminary review suggested a significant improvement.

The practice had a chaperone policy and a notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. Only nurses carried out chaperone duties and all but two had received appropriate training for this role.

Medicines management

The practice had comprehensive policies and procedures relevant to the safe management of medicines and prescribing practice. One of the practice's GPs was the prescribing lead and regularly attended meetings with the CCG to discuss medicines' management.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. Records showed that fridge temperature checks were carried out to ensure medication was stored at the appropriate temperature. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription pads were kept securely in a locked cupboard. However, no record was kept of prescriptions being taken out of the cupboard to ensure a robust audit trail and to prevent fraud. We also noted that not all scripts were signed for by the receiving pharmacy, including those scripts for controlled drugs.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Information provided by the practice showed that they regularly analysed and reviewed their prescribing habits, and also followed prompts from the prescribing team at the CCG. The GPs used a specialist computer programme to support medicine prescribing decisions and prescribing rates were similar to national figures for hypnotics, non-steroid anti-inflammatory drugs and antibiotics.

The practice planned to introduce electronic prescribing in November 2015 to allow patients greater choice in where they collected their medicines from.

Cleanliness and infection control

We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting area, corridors, meeting rooms and

treatment rooms. Hand hygiene stations were available in corridors. The patient toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked three treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. There were prompter posters above each sink reminding staff of the correct way to wash their hands.

We viewed waste notes that showed the practice dealt appropriately with clinical waste. The practice had completed a risk assessment for legionella (a bacterium that can contaminate water systems in buildings) and we saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

Audits of cleanliness and infection control were undertaken; we viewed details of the most recent one conducted in September 2015 where the practice had scored 97%. The audit had revealed that not all treatment rooms had mixer taps to allow hand washing at the correct temperature. The practice manager had ordered new taps as a result.

Equipment.

Staff told us the practice was well equipped and requests for repairs or replacement equipment were dealt with swiftly. All equipment was tested and maintained and we viewed evidence of the calibration and service of relevant equipment; for example spirometers, nebulisers and foetal heart monitors. Portable appliance testing had been completed in July 2015. We also viewed a detailed appliance register detailing all equipment the practice held.

Staffing and recruitment

The practice had a recruitment policy that described the process when employing new staff. This included obtaining proof of identity, checking skills and qualifications, registration with professional bodies where relevant, employment references and whether a Disclosure and Barring Service (DBS) check was necessary. However, personnel files we reviewed contained significant gaps in staff's recruitment information. For example, we checked the files for two nurses and there was no record of the qualifications and training they had undertaken and no record of their employment interview. Files for other staff did not contain evidence of their interview, proof of their identification, their DBS check or references.

Requires improvement

Are services safe?

At the time of our inspection the practice was relying on agency staff to cover two vacant administration posts. However, staff told us there were usually enough of them to maintain the smooth running of the practice. The practice's medical secretaries were able to help in reception at busy times of the day. Vacant GP shifts were usually covered by ex-partners of the practice or by current GPs, as several were part-time and could work flexibly.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We viewed comprehensive risk assessments in relation to legionella management, fire safety and potential hazards identified in the practice's building and environment. Regular checks of the building and its environment were completed to ensure both staff and patients were safe.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment including access to oxygen and an automated external defibrillator (used in cardiac emergencies) was available. Following the collapse of a patient in the snow outside the practice, a specialist blanket had been purchased by the practice. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. However, one of the nurse's told us that the oxygen cylinder was large and very heavy, making it dangerous to handle and difficult to transport quickly. We checked that the pads for the automated external defibrillator which were within their expiry date. 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 carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and fire equipment was regularly serviced to ensure its effective operation. However, staff did not regularly practice fire drills to ensure they knew what to do in the event of an emergency.

There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to any emergency, and a panic button in the reception area.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had been a training practice for many years and had been inspected regularly to ensure they maintained a good standard of clinical care. As a result, all their clinical guidelines were up to date and easily accessible on its intranet. They conformed to NICE and CCG guidelines. One nurse told us that she regularly received NICE guidelines updates and each nurse took responsibility for updating relevant protocols in their light.

Nurses at the practice held chronic disease management meetings once a month where any new developments or guidelines were discussed. For example, we viewed minutes of a meeting held in February 2015 where new asthma guidance was reviewed. In April 2015, new guidelines in relation to chronic kidney disease were discussed. These meetings were also used to cascade information to the nursing team following any courses or study days they had undertaken.

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. We saw evidence that QOF results were discussed regularly at the nurses' monthly meetings.

The practice had achieved 99.1% of the total number of points available, with 9.1% exception reporting and was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed;

- Performance for diabetes related indicators was at 97.7 %. This was 9.9 percentage points above the CCG average, and 8.5 percentage points above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100%. This was 0.3 percentage points above the CCG average, and 2.2 percentage points above the national average.
- Performance for mental health related indicators was 100%. This was 4.8 percentage points above the CCG average and 7.2 percentage points above the national average.
- The dementia diagnosis rate was 100%. This was 3.8 percentage points above the CCG average and 5.5 percentage points above the national average.

Structured annual reviews were also undertaken for people with long-term conditions and data we viewed showed that 54% of diabetic patients had received an annual review during 2014-15, and 91.5% of patients with chronic obstructive pulmonary disease had received an annual review. 57% of people with a learning disability had received an annual health check.

The practice had identified its patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. The practice confirmed that they had developed personalised care plans to improve the quality and co-ordination of care for these patients.

Clinical audits were carried out and we were shown five audits that included the practice's pregabalin and nitrofurantoin prescribing, an audit to check that referral letters were written in accordance with local and national guidelines and an audit on the use of hormone replacement therapy. However, none of these audit cycles had been completedand therefore the practice could not demonstrate that the changes implemented as a result of the audits, had been successful yet.

The practice had partaken in a Clinical Commissioning Group (CCG) run peer review of referrals and each GP received a score on the quality and appropriateness of their referrals. They had also participated in an audit run by the Norfolk and Norwich University Hospital in relation to the quality of their cervical smear samples.

The practice monitored its performance against other practices and compared to the local CCG average it had lower referral rates, lower A&E attendances, and lower unplanned admissions rates.

Good

Are services effective?

(for example, treatment is effective)

The practice was very active in research and had taken part in a number studies to monitor and improve patient outcomes for those with atrial fibrillation, asthma and cancer.

Effective staffing

We found that staff had the skills, knowledge and experience to deliver effective care and treatment. The practice had a very good skill mix which included an advanced nurse practitioner who was able to see and treat a broader range of patients than the practice nurses. Each nurse had a lead role in specific chronic diseases such as respiratory conditions, diabetes and wound care and was able to provide expertise and experience around this. Two of the health care assistants had undertaken training in ear irrigation and now ran their own clinics. They were also able to administer flu vaccinations, fit ambulatory blood pressure monitors and provide ECGs to patients.

The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. One nurse told us that her requests for training were met, and that recently all the practice's nurses had been funded to attend a specialist diabetes conference in London to ensure their knowledge and skills were kept up to date. Educational meetings for clinical staff were held once a fortnight.

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. One of the practice's reception staff told us the training she had received was good and she had recently learned about domestic violence, dementia and safeguarding.

All staff had received an appraisal of their performance within the last 12 months. However, there were no specific training and development plans for the practice's administrative staff.

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.

Patients' details were forwarded to the out of hours services if the GP had any concerns that might arise, especially for patients at the end of their life. All patients' discharge letters were reviewed by the patient's named GP and those with complex needs were telephoned or visited to ensure their welfare.

The practice held regular meetings with the Integrated Care Organisation and Age UK to discuss patients with more complex needs and to coordinate a community response. The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had implemented the Gold Standards Framework for end of life care and worked closely with the community palliative care team to ensure it was implemented.

The practice had strong links with two care homes in the local area and provided a weekly 'ward round' to them. Staff from these settings told us that the practice's clinicians worked well with them to improve their residents' health and well-being. One care home manager we spoke with told us that the practice manager had visited the home to show staff how to use the on-line system for booking repeat prescriptions which she had found very useful.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. Most clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their work. One GP reported that, as a training practice, these issues were often discussed with registrars and students. The GPs who provided services to local care homes had developed additional knowledge in supporting those patients who lacked capacity to make decisions for themselves, and those whose liberty was deprived.

Good

Are services effective?

(for example, treatment is effective)

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. This helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

The practice used written patient consent forms for a number of procedures including minor surgery. These forms were scanned into the patients' notes and we saw evidence of this on the notes we reviewed.

One care home manager told us that the practice's GPs undertook mental capacity assessments for their residents if needed, so that patients who could not make decisions for themselves were protected. GPs also completed resuscitation forms with residents to ensure their wishes were respected in the event of their death.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice had an informative website which provided information about health and care topics and there were leaflets in the waiting rooms, giving patients information on a range of medical conditions. A health trainer was available at the practice every Monday morning to offer patients advice about smoking cessation and weight management.

The practice provided medical services to a local independent school, delivering health promotion and advice to its pupils. One GP regularly provided health promotional advice on radio Norwich. Another GP was trained as a breast feeding counsellor and provided voluntary breast feeding counselling at a local hospital and a children's centre.

The practice had a comprehensive screening programme and young patients between 18-25 years were offered chlamydia screening. The practice's uptake for the cervical screening programme was 78%, which was comparable to the national average of 82%.

Childhood immunisation rates for the vaccinations given were comparable to national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 96%, and five year olds from 90% to 97%. The practice offered seasonal flu immunisation and pneumococcal vaccination for those at risk. Flu vaccination rates for the over 65s were 79%, and at risk groups 60%. These were above national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74 years.193 patients aged between 40-74 years had received a health check in 2014-2015.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All of the 22 patient CQC comment cards we received were positive about the service experienced. The cards highlighted that people were treated in a way that they liked, and received professional, caring and effective treatment from staff. We spent time in the patients' waiting area and found the general atmosphere was welcoming and friendly. We observed staff being consistently cheerful and helpful to patients.

Confidentiality was taken seriously by staff and they provided us with many practical examples of how they maintained patients' privacy. They told us that they ensured that all patient paperwork was turned over when on reception so it couldn't be seen, that they offered a room to patients who wanted to discuss anything in private and that they didn't use patients' names when answering telephone calls so that their identity was protected. Telephones on the front reception desk were used for internal communication only phones that were used to make and receive calls from patients were located behind a screen to ensure their confidentiality.

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.

The GPs ran personal lists, allowing them to get to know their patients well and ensuring that they received good continuity of care. Patients told us they particularly valued this.

Results from the national GP patient survey showed patients were happy with how they were treated. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.
- 87% 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%.
- 96% 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%.
- 83% of patients with a preferred GP usually got to see or speak to that GP compared with a CCG average of 61% and a national average of 60%.

Care planning and involvement in decisions about care and treatment

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

We spoke with the managers of two care homes supported by the practice who told us that the GPs who visited offered particularly good end of life care for their residents, and always involved families in key decisions about treatment. We saw evidence in the patient notes that we reviewed that GPs actively discussed and recorded a number of different treatment options with patients, so that they were well informed of the choices available to them.

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

- 95 % said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.

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

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

The practice had access to a range of mental health services on site, that could provide additional support to patients if needed. 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. Written information about local services was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. The practice's GPs attended peer review meetings run by the local CCG and the practice manager attended a local practice managers' forum which met monthly. He reported this was useful as external speakers gave presentations and the meetings were also used to discuss forthcoming Department of Health changes that might affect GP practices. The practice manager had also provided IT support to the CCG, and had set up standardised computer templates to ensure consistency across Norwich GP practices.

The practice offered a wide range of services to patients in addition to chronic disease management including minor surgery, NHS health checks, audiometry, family planning (including contraceptive implants and coils) and chlamydia screening. Midwives attended twice a week, and two physiotherapists were employed to meet patients' needs. The practice participated in a 'telederm' service allowing patients' skin and lesions to be assessed remotely by a dermatologist

There were also a number of additional non-NHS services provided at the practice including yellow fever vaccinations and private medical reports.

The practice offered a weekly 'ward round' to two local care homes, providing regular contact and continuity of care for residents living there.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example, there were longer appointments available for people with a learning disability and urgent access appointments were available for children and those with serious medical conditions. Nurses offered home visits for diabetic reviews to patients unable to attend the practice. There were male and female GPs in the practice allowing patients to see a GP of their preferred gender.

The premises had ground floor consultation rooms and a fully accessible disabled toilet. A hearing loop was available to help those patients with a hearing impairment. The entrance was automated making it easy for wheelchairs users and those with disabilities to open. However, there were no easy riser chairs, or wide seating available in waiting areas to accommodate patients with mobility needs, and no lowered section of the reception desk for wheelchair users.

Access to the service

Information was available to patients about appointments on the practice's website and in its patient information leaflet. This included surgery times and how to book appointments through the website.

The practice was open between 8am to 1pm and 2pm-6pm Monday to Friday. Appointments were from 8am - 12pm every morning and 2pm to 6pm daily. The morning appointments were pre-bookable, while afternoon appointments were book on the day, giving flexibility to patients. Staff told us that the 8am appointments were particularly popular for patients who worked. In addition to appointments that could be booked up to eight weeks in advance, urgent appointments were also available for people that needed them. Telephone advice was available and patients who wished to speak to their GP could call before 10 am. There was a duty doctor available at the practice throughout the day for telephone advice and any urgent visits that were needed. One member of reception staff told us that more doctors were available on a Monday and Friday as these were particularly busy times for the practice.

We visited on 13 October 2015 and found that the next routine appointment was available the next day on 14 October.

Patients were able to book appointments, order repeat prescriptions and access their summary care records on-line.

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

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 80% patients said they could get through easily to the surgery by phone compared to the CCG average of 73% and national average of 73%.
- 77% patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 78% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 65% and national average of 65%.

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. Information about how to raise concerns was available to patients in the practice's information booklet and on its website. However there was no information about how to complain in the waiting area, to make it easily accessible to patients.

Complaints were discussed at the fortnightly practice meeting, evidence of which we saw from the minutes of meetings that took place in June and July 2015. We looked at the paperwork in relation to 10 complaints received by the practice in the last 12 months and found they had been managed in an empathetic, open and timely way. Lessons had been learnt from the complaints and action had been taken to improve the quality of care. For example, one staff member told us that a recent complaint in relation to a perceived lack of empathy shown by reception staff to a recently bereaved patient was shared widely in the team and discussed with staff as to how better to respond in the situation. Another complaint involved a palliative care patient who had found problems with their continuity of their care as the duty GP role was spread between four GPs in any one day. To prevent this problem reoccurring, it was decided that the GP who first has contact with a palliative care patient would continue with that patients' care throughout the day.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision 'to deliver good quality individual patients care' and which placed great value on, 'maintaining the traditional values of a named family doctor to provide continuity of care to patients'. Staff told us they had been consulted about this vision and it was also available on the practice's website making it accessible to patients.

We found that practice staff were well aware of future challenges they faced including an increasing patient population due to housing development, the limitation of its premises, the need to work closely with other practices locally and the possible introduction of a 7 day service.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We viewed a sample of these and found that they had been regularly reviewed to ensure they remained relevant and up to date. Staff were required to confirm that they had read and understood the policies.

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

Staff received regular appraisal and one to one meetings with one of the two GPs specifically responsible for staff development, and the deputy practice manager. Staff told us that their appraisal was useful and they received feedback about their everyday performance at them.

Communication across the practice was structured around key scheduled meetings. There were fortnightly practice meetings involving the GPs and practice managers, monthly nurses meetings and staff meetings involving all administrative staff and staff liaison GPs every quarter.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. Staff told us they felt well supported in their work and described the partners and managers as caring. One staff member told us that the practice had been particularly understanding and supportive of some personal family issues they had experienced.

Staff told us that regular team meetings were held. However we noted that there was a lack of active participation by administrative staff in the quarterly staff meetings and they were not asked to contribute their ideas for the agenda.

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. The practice had undertaken an extensive survey in 2014 with over 600 respondents. Key issues had been identified such as car parking, improvement in telephone answering and the availability of blood tests. The practice had implemented a number of measures to address these issues. It had liaised with the local county councillors to use a council owner car park nearby. The practice's secretaries now assisted at busy telephone times, allowing a 25% increase in call handlers during this time. A review of the practice providing phlebotomy services had been undertaken but found not to be viable.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. The practice regularly responded to patients' comments received on the NHS Choices web site.

Staff told us their ideas and suggestions were listened to by the partners and practice manager. For example, a suggestion by the medical secretaries to swap offices with the practice manager so that they did not feel so isolated had been agreed. One of the nurses told us her suggestion to introduce diabetes checks for house bound patients had been implemented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation: 19 – Fit and proper persons employed The practice must operate robust recruitment procedures to ensure that only fit and proper staff are employed. Regulation 19 (2) and (3)