The Hollies Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We visited The Hollies Surgery on the 22 January 2015 and carried out a comprehensive inspection. We found that the practice provided a safe, effective, caring, responsive and well led service. The overall rating for this practice is good.

We examined patient care across the following population groups: older people; those with long term medical conditions; families, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

Our key findings were as follows:

- Patients were satisfied with the appointment system and felt they were treated with dignity, care and respect. They were involved in decisions about their care and treatment and were happy with the care that they received from the practice.
- The practice was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- The needs of patients were understood and services were offered to meet these.
- The practice effectively used the benefits of being part of a large partnership, whilst retaining the individuality of being a small practice.
- There were a number of clinical teams who specialised in different areas, in order to provide a focussed and effective service to patients.

We saw some areas of outstanding practice:

- The practice offered dementia screening for patients with Down's Syndrome who were aged over 40 years of age.
- The practice worked well with their patient representative group. There was evidence that they

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provided external oversight and scrutiny in relation to complaints and significant events. A patient representative was also on the interview panel for the Chief Executive Post.

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 report incidents and near misses. Lessons were learned and communicated across the Vida Healthcare GP practices in the area to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Staff had a good understanding of the types of abuse and their responsibilities in relation to safeguarding. Information was provided to support staff in relation to safeguarding children and adults. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed that patient outcomes were at, or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned for. Staff at the practice had received an annual appraisal. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice in line with others in the same clinical commissioning group (CCG) area, for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect, ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Area Team and clinical commissioning group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same day. The practice had good facilities and was well equipped to treat

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patients and meet their needs. There was a complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff from the practice and across Vida Healthcare.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and staff were aware of their responsibilities in relation to this. 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 regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify and monitor risk. The practice sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG) who arranged educational events for patients which were supported by the practice. Representatives from this group were also involved in providing external oversight and scrutiny in relation to themes and learning from complaints and significant events. Staff had received inductions, regular performance reviews and attended staff meetings and educational 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 the practice had good outcomes for conditions commonly found amongst older people. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. 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 was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice had a specialist clinical team for a range of long term conditions including diabetes, asthma and chronic obstructive pulmonary disease (COPD). Each team had a GP lead and the team met regularly to organise the care and treatment of patients, share good practice and review their performance. All patients with long term conditions had structured reviews, at least annually, with most patients being recalled for a review every nine months to check their health and medication needs were being met. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. For those people with the most complex needs the GPs and nurses worked with relevant health 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. Patients told us, and we saw evidence that, children and young people were treated in an age appropriate way and recognised as individuals. Appointments 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 health visitors. Immunisation rates were relatively high for all standard childhood immunisations. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

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Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age adults (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 offer continuity of care. The practice offered extended hours appointments on two evenings a week. Patients could book appointments in a range of ways to meet their circumstances. These included being able to book appointments any time of the day either on line, or via an automated telephone booking line. The practice offered telephone consultations as well as a full range of health promotion and screening which reflected the needs for this population.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed above the clinical commissioning group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability and 75% had received an annual health checks. Annual health checks were undertaken in the patient's own home, if necessary, for example if they were too anxious to have this completed at the practice. A process was in place to follow up patients who had not attended for their appointment.

We were told that longer appointments were given to patients who needed more time to communicate during a consultation, for example people who needed an interpreter. There were arrangements for supporting patients whose first language was not English.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice had above average

outcomes for people with mental health needs, including those with dementia. The practice ran a clinic with the Norfolk Recovery Partnership to ensure that patients with drug and alcohol needs received appropriate support. Patients could also be referred by a GP and seen at the mental health clinic which was held at another Vida Healthcare practice in the local area. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. We were told that dementia screening was undertaken, which included proactive screening for patients with Downs Syndrome who were over the age of 40. Depending on the results, patients were referred to the local dementia specialist centre for further assessment. The practice had advance care planning in place for patients with dementia.

Summary of findings

What people who use the service say

We spoke with eight patients on the day of our inspection. This included two members of the patient participation group, a group of patient representatives and staff, set up for the purpose of consulting and providing feedback in order to improve quality and standards. Patients reported that they were treated with kindness, respect and dignity by all the staff at the practice, were provided with information about their care and treatment and involved in decisions. Most patients reported that they were able to get an appointment easily, although two patients reported this was difficult.

We spoke with representatives from five care homes, where residents were registered with the practice. We were told that the GPs made home visits when they were requested. They listened and involved patients in decisions about their care and treatment and there was effective liaison with family members. We received positive feedback regarding proactive clinical care, particularly in relation to end of life care and people with mental health needs.

We reviewed four comment cards that had been collected from patients in advance of our visit, via a sealed box left in the waiting room. Two of these reported positive experiences of the service provided to patients. The other two related to dissatisfaction with the appointment system.

Following the inspection we spoke with one patient who was registered with the practice and who had not been seen for over two years. They confirmed that they had not accessed the practice as they had not needed to and that they had no difficulties with obtaining access to the practice.

Outstanding practice

- The practice offered dementia screening for patients with Down's Syndrome who were aged over 40 years of age.
- The practice worked well with their patient representative group. There was evidence that they provided external oversight and scrutiny in relation to complaints and significant events. A patient representative was also on the interview panel for the Chief Executive Post.

The Hollies Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included the Chief Executive of the CQC.

Background to The Hollies Surgery

The Hollies Surgery, in the West Norfolk clinical commissioning group (CCG) area, provides a range of alternative primary medical services to approximately 3600 registered patients living in Downham Market and the surrounding villages. According to Public Health England information, the patient population has a slightly higher than average number of patients under 18 years of age compared to the practice average across England. It has a slightly higher proportion of patients aged over 65, 75 and a slightly higher than average number of patients aged over 85 compared to the practice average across England. Income deprivation affecting children and older people is slightly lower than the practice average across England.

The Hollies is provided by Vida Healthcare, a partnership made up of 20 partners who hold financial and managerial responsibility for six GP practices in Norfolk. At The Hollies Surgery there is a GP partner, a salaried GP and a long term locum GP, seven nurses, two health care assistants and a number of receptionists and administration staff. There is also a management team which includes a practice manager, a head of patient's services, a head of people and governance and a head of finance. The practice is a training practice for medical students and qualified doctors who are training to be GPs.

The practice provides a range of clinics and services, which are detailed in this report, and operates between the hours of 08:00am and 18:30pm, Monday to Friday with extended hours until 19:00pm on a Monday and a Thursday. Outside of practice opening hours a service is provided by another health care provider (Medicom) by patients dialling the NHS 111 service.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This location had not been inspected before.

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

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the

service. We spoke with representatives from five care homes where patients were registered with the practice. We talked to the local Clinical Commissioning Group (CCG), the NHS area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced visit on 22 January 2015. During our visit we spoke with a range of staff, including GPs, nurses, reception, administration staff, the practice manager and members of the management team. We spoke with two members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We also spoke with eight patients who used the practice. We reviewed four comments cards where patients had shared their views and experiences of the practice. We spoke with representatives from five residential homes where patients were registered with the practice. We observed how people were being cared for and reviewed the treatment records of patients. We spoke with one patient by telephone to obtain their views in relation to the accessibility of the service provided by the practice.

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

- 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 living in vulnerable circumstances

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety records and incident reports and minutes of meetings where these were discussed. These were discussed in a range of meetings, including clinical meetings, governance meetings and in the chronic disease management team meetings. We were told that records of meetings where these had been discussed had been kept since 2011, when Vida Healthcare started managing the practice. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

We were told that themes and learning identified and completed as a result of significant events and complaints, were shared at a 'primary care group' meeting, on a six monthly basis. This group was made up of representatives from the patient participation group and clinical and managerial staff. This enabled some external overview and scrutiny in relation to complaints and significant events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording, monitoring and learning from significant events, incidents and accidents. Records were kept of significant events that had occurred since 2011, when Vida Healthcare took over responsibility for the practice.

Incident reporting forms and guidance were available on the practice intranet. Once completed these were sent to the management team who allocated them to the relevant manager lead for investigation. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result was shown to us. One example of this was where a referral request had been sent to an individual secretary which had resulted in a delay in the referral being made. A group email address was now in place so that referral letters were completed in a timely way.

Significant events were discussed at the monthly clinical governance meeting and a dedicated meeting occurred on a quarterly basis to review actions from past significant events and complaints. We noted that for significant events or complaints, where a learning need had been identified, these were referred to the education lead who organised training and education in order to meet the identified learning need. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

National patient safety alerts were disseminated by the head of people and governance to practice staff electronically. Where staff were responsible for undertaking a specific action in relation to the alert, then a process was in place for this action to be followed up until completion. Safety alerts were also available on the practice intranet. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

We looked at three staff files. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We were told that the safeguarding policies were being updated. Up to date child protection guidance which included referral information for safeguarding children and safeguarding vulnerable adults, was displayed in consultation and treatment rooms for staff ease.

The practice had a dedicated GP appointed as lead in safeguarding who had been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern.

Good

Are services safe?

The practice had a system to highlight vulnerable children, young people and vulnerable adult patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended for an appointment. An example of this was for children who were on the 'at risk' register.

A chaperone policy was in place and notices informing patients of this service were displayed in the practice. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff and patients we spoke with confirmed that chaperones were used. We were told by the head of people and governance that clinical staff acted as chaperones and this was confirmed by the clinical staff we spoke with. The management team told us they had made a decision to stop non-clinical staff acting as chaperones as they had not all had a criminal records check via the Disclosure and Barring Service. However when these checks had been completed for non-clinical staff, they would be used for chaperoning, if this was necessary.

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. There was a clear policy for ensuring medicines were kept at the required temperatures. The staff we spoke with were aware of their responsibility for ensuring that medicines requiring refrigeration were stored appropriately. We noted that refrigerator temperatures were taken daily, including the minimum and maximum temperature and these were also recorded on the computer.

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. Expired and unwanted medicines were disposed of in line with waste regulations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patient's repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. Patients we spoke with had no concerns about cleanliness or infection control. The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use and posters promoting good hand hygiene were located throughout the practice. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in consultation and treatment rooms.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves and coverings were available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy.

We saw there were cleaning schedules in place which detailed the frequency of cleaning of different areas of the practice. Cleaning records were also kept that helped the practice to monitor the effectiveness of the cleaning process on a weekly basis. Spot checks of the cleaning were also undertaken. A control of substances hazardous to health (COSHH) risk assessment had been completed and guidance sheets were available for cleaning materials in use at the practice.

Vida Healthcare had a lead nurse for infection prevention and control, who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We were told that staff received induction training about infection control specific to their role and there after annual updates. Staff we spoke with confirmed that this happened. We saw evidence that the nurse lead had carried out audits for each of the last two years and that any improvements identified for action were completed on time. The findings from the audits were discussed and shared across the Vida healthcare practices.

The practice had undertaken a legionella risk assessment which was in date until December 2015. Legionella is a bacterium that can grow in contaminated water and can be potentially fatal.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was

Good

Are services safe?

suitably equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the diabetes clinic, and for procedures, such as minor surgery. The equipment was in good order. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date, which was May 2014. Medical equipment had been calibrated on 29 October 2014.

Staffing & Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice had procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. All clinical staff had a criminal record check through the Disclosure and Barring Service. Checks made through the Disclosure and Barring Service help to ensure a person's suitability to work with vulnerable patients.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were enough staff to maintain the running of the practice and there were enough staff on duty to ensure patients were kept safe.

Monitoring Safety & 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. These included weekly formal checks and spot checks of the building and the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

The staff we spoke with described what they would do in urgent and emergency situations. The responses we received demonstrated that staff had been supported in being able to undertake their role effectively. For example, reception staff told us how they would identify and respond to a patient with deteriorating health whilst they were waiting to be seen.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing the majority of staff had received training in basic life support. Following the inspection the provider confirmed that all remaining staff had now received basic life support training. Emergency equipment was available which included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

The practice carried a stock of medicines for use in the event of a medical emergency. These were available in a secure area of the practice and staff we spoke with knew of their location. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included loss of premises, loss of computer system, loss of telephone system, loss of essential supplies and incapacity of GPs. Each risk identified had mitigating actions recorded in order to reduce and manage the risk. The document also contained relevant key individual and organisational contact details for staff to refer to. For example, contact details of the company where medical stationary can be obtained.

A fire risk assessment had been undertaken by the landlord of the building. We looked at three staff files which showed that staff had completed fire training and we were told by the head of people and governance that regular fire drills were undertaken. We saw records for the maintenance of the fire-fighting equipment and fire alarm.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The needs of the practice population were understood and systems were in place to address identified needs. We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs. Patients with diabetes who needed to start taking insulin had this initiated at the practice. This was to ensure continuity of care and to save patients having to travel.

The GPs told us they lead specialist clinical teams in areas such as diabetes, heart disease, asthma, chronic obstructive pulmonary disease and women's health. These teams each had a lead GP with specialist expertise and specialist nursing and administration staff. Each team met regularly in order to discuss patients, organise patient reviews, review their performance, share new clinical guidelines and relevant safety alerts and update their knowledge. The clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included for example, data input, clinical review scheduling, and medicines management. 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 the latest prescribing guidance was being used.

We looked at a number of clinical audits that had been undertaken in the last three years and there was evidence of improvements to patients care and treatment as a result. One example was ensuring for patients on repeat prescriptions for iron, there had been an investigation into the cause of iron deficiency or this had been refused despite being fully informed of the risks. Another example confirmed that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data showed that the practice had a higher prevalence of heart failure, depression and dementia than the CCG and England average and scored higher than the CCG and England average for all the clinical indicators for these conditions. The practice met all the minimum standards for QOF in asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease (lung disease), dementia, depression, heart failure, hypertension, hypothyroidism, learning disability, mental health, osteoporosis, palliative care, peripheral arterial disease, rheumatoid arthritis, secondary prevention of coronary heart disease and stroke and transient ischaemic attack. The practice performed above the CCG, but below the England average for epilepsy.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance

Good

Are services effective?

(for example, treatment is effective)

of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Staff spoke positively about the culture in the practice about quality improvement.

Effective staffing

All new staff underwent a period of induction to the practice. We saw that an induction plan was in place for new staff which was tailored to their role. For example there was an induction plan for non-clinical staff and another one for GPs. New staff had to read and sign that they have read the staff handbook, confidentiality policy. The staff we spoke with confirmed that they had received an induction appropriate to their role.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as infection control, fire and basic life support. A good skill mix was noted amongst the doctors and nurses with additional training in areas including diabetes, women's health and coronary heart disease. We were told that all GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

We were told that all staff undertook annual appraisals. The lead GP for each of the clinical areas undertook the appraisal for the clinical staff in that team. We looked at three staff files and found evidence of completed appraisals within the previous year. The appraisals we looked at identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in encouraging and providing training and funding for relevant courses. For example, one member of staff was undertaking the Warwick diploma course on diabetes.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties, for example, cervical cytology. The practice also employed specialist nurses in areas which included coronary heart disease, diabetes, well woman, chronic obstructive pulmonary disease and asthma. Those with extended roles were also able to demonstrate they had appropriate training to fulfil these roles.

There was a process in place to deal with any performance issues identified. This involved the clinical governance lead GP and the head of people and governance meeting with the member of staff and agreeing a personal development plan. The member of staff was mentored through their learning to completion of the plan.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. Staff we spoke with were aware of their responsibility in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. These were usually reviewed by the GP who was responsible for the patient's care. There was a system in place for GPs to cover for each other during times of absence, to ensure that patient correspondence was reviewed and actioned in a timely way. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patents. This included for example, those patients with a new cancer diagnosis, patients with end of life care needs, children on the 'at risk' register and patients at risk of falls. These meetings were attended by the GPs, social care representatives, district nurses, palliative care nurses and representatives from the community rehabilitation team. We were told that decisions about care planning were documented in a shared care record. We also noted that the practice reviewed patients who had died to identify if any improvements could have been made in relation to the care and support they received at the end of their life.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). Patients who had had an unplanned admission to hospital

Good

Are services effective?

(for example, treatment is effective)

were reviewed by the multi-disciplinary team and support and actions agreed in order to minimise the risk of readmission to hospital. These patients were also reviewed at the monthly multi-disciplinary meetings.

Information Sharing

Records we saw showed that multidisciplinary meetings took place at the practice with a range of other health professionals in attendance, to co-ordinate care and meet the needs of the patients. We saw that information was shared appropriately between the agencies involved. We saw that information regarding patients who were at the end of life was shared with the out of hour's provider. This ensured that care and support would be seamless if the patient needed a GP out of hours.

The practice used an established electronic patient records management system (known as SystmOne) which was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The system was set up to enable alerts to be communicated about particular patients, such as information about children known to be at risk. For example, for patients who were caring for others, the caring responsibility was marked on the summary record of a patient when they attended the practice as a patient in their own right so that the social and psychological factors associated with caring for others could be addressed in care planning.

Consent to care and treatment

We looked at the practice consent policies and forms for documenting consent for specific interventions. The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients that we spoke with and received comments from confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. Staff understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We saw the practice's Mental Capacity Act (MCA) (2005) policy. The Mental Capacity Act (MCA) (2005) is used for adults who lack capacity to make specific decisions. The practice policy provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. The clinicians we spoke with were aware of the requirements of the Mental Capacity Act (2005).They understood the key parts of the legislation and were able to describe how they implemented it in their practice. All staff were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have mental capacity.

The practice had not had an instance where restraint had been required in the last 3 years but staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

There was a large range of up to date health promotion information available at the practice and on the practice website with information to promote good physical and mental health and lifestyle choices. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. There was information about services to support them in doing this, such as smoking cessation, a mental health clinic and a drug and alcohol clinic.

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. The practice proactively identified people who needed extra support in relation to health promotion and the prevention of ill-health. We saw from the Quality and Outcomes Framework data that we reviewed, the practice scored the

Good

Are services effective?

(for example, treatment is effective)

same as or above the CCG and England average for all the public health indicators. These include for example, cardiovascular disease, primary prevention, cervical screening, child health surveillance, contraception, maternity services, obesity and smoking.

We saw that new patients were invited into the surgery when they registered to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a practice nurse. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner. We noted a culture amongst the clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. The practice kept a register of all patients with dementia and 77% of patients had received an annual review. The practice also kept a register of all patients with learning disabilities and offered them an annual health check. We saw that the nurse who completed the health checks had received additional training to undertake this work, which had included spending time with the learning disability health team. We saw that appointments had been scheduled for people with a learning disability to have their annual health check. We were told by the nurse who completed these health checks that where appropriate they would undertake the health check in the persons own home, for example if the patient was anxious. The practice informed us that 75% of patients with a learning disability had received an annual health check. There was a clear process in place for following up patients who had not responded to their health check invitation letter and also for patients who had not attended for their appointment.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored the same as or higher than the clinical commissioning group (CCG) and England average in all the public health indicators. These included for example, cervical screening, child health surveillance, contraception, obesity and smoking.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

There was a person centred culture at the practice and staff and management were committed to working in partnership with patients. During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. All of the patients we spoke with, and received comments from during the inspection made positive comments about the practice and the service they provided. Patients reported that all the staff were friendly and helpful and they were satisfied with the care that they received.

Reception staff told us that facilities were available for patients to talk confidentially when they were at the reception desk, however there were no notices on display informing patients that this was available. The head of people and governance staff member confirmed the day after the inspection that notices were now displayed in the practice to inform patients that this facility was available. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their role in relation to confidentiality.

We saw that patients' confidentiality was respected when care was being delivered and during discussions that staff were having with patients. Curtains were provided in consulting and treatment 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.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient Survey, which was published on 8 January 2015 and a survey of 178 patients undertaken by the practice's Patient Participation Group (PPG) during 2013 to 2014. The evidence from both of these sources showed patients had positive levels of satisfaction with the service provided. The PPG survey showed satisfaction with waiting times, the quality of the doctor and nurse care and the reception staff customer service. The National GP patient survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (84%) and by their GP (90%). 95% of patients reported that the reception staff were helpful. In relation to whether staff listened to them 90% reported this being good for nurses and 95% for GPs. 95% of respondents described their overall experience of the practice as good and 88% of patients stated they would recommend the practice. Most of these results were average when compared with other practices in the Clinical Commissioning Group (CCG) area.

Care planning and involvement in decisions about care and treatment

We looked at data from the 2015 National GP Patient Survey, which was published on 8 January 2015. Patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national GP patient survey, published on 8 January 2015, showed 92% of practice respondents said the GP involved them in care decisions, 97% felt the GP was good at explaining tests and treatments and 94% said the GP was good at giving them time. In relation to nurses, 84% said they involved them in care decisions; 91% felt they were good at explaining tests and treatments and 90% said they were good at giving them enough time. Most of these results were average when compared with other practices in the clinical commissioning group (CCG) area.

Patients we spoke with on the day of our inspection 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

We reviewed the 2015 National GP patient survey information which related to the emotional support provided by the practice. The practice were rated above the clinical commissioning group (CCG) average for the proportion of patients who stated that the last time they

Good

Are services caring?

saw or spoke with a GP (87%) they were good or very good at treating them with care and concern. However for the same question in relation to nurses, the practice scored below the CCG average, with 76%.

The patients and their representatives we spoke with, and received comments from, expressed that they were supported or thought they would be supported, if this was necessary, to cope emotionally with care and treatment by staff at the practice. For example, one patient representative we spoke with explained how they were supported throughout the patient's end of life care.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

New patients who registered at the practice were asked if they had a carer and if their carer was registered at the practice. They were also asked if they were a carer and if the person they cared for was registered at the practice. This information was put onto the patient's record to alert practice staff so that appropriate support could be given. Information was available in the waiting room and on the practice website, which sign posted people to a number of support groups and organisations for carers. The information on the website was supplied by NHS Choices.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. We received positive feedback in relation to the support provided by the practice during end of life care, from representatives from two care homes where patients were registered with the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs.

Longer appointments were available for people who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to some of the local care homes on a specific day each week by a named GP, and to those patients who needed one. We spoke with representatives from four care homes, all of whom provided positive feedback on the service provided by the staff at the practice.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) This included for example, advertising opening times more widely, with increased use of social media and more leaflets being made accessible for patients. The PPG informed us that they held information sessions during which they invited external speakers to present on specialist subjects and long term conditions to the PPG, patients and general public. Patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs.

The practice had a palliative care register and had regular internal, as well as multi-disciplinary meetings to discuss patient and their families care and support needs. We received positive feedback from representatives of the care homes where patients were registered with the practice. This was in relation to the proactive support and care provided by the GPs to the patient, their family and carers at the end of their life.

Tackle inequity and promote equality

The practice was situated in a single level building, near the centre of Downham Market. There were automatic doors to assist patients with mobility needs or with children in pushchairs to gain easy access. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice had recently undertaken an audit of the accessibility to the practice and within the practice. This had been sent to the landlords of the building in order for them to consider improvements that could be made to the building.

There was a system to highlight vulnerable patients on the practice's electronic records. This helped to ensure staff were aware of any relevant issues when patients contacted the practice or attended appointments. For example if a patient's first language was not English, this was documented so that interpreting services could be arranged if these were needed. Patients who were using interpreting services were also provided with a double appointment to ensure adequate time was given for their consultation. We were told that the practice used an interpreting service called Cintra, who provided a face to face or telephone interpreting service.

Access to the service

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments, telephone consultations and home visits. Appointments could be booked by visiting the practice, on line or by telephone, through a receptionist, or via an automated booking service. The practice offered extended hours appointments until 19:00pm on a Monday and a Thursday evenings and both nurse and GP appointments were available during these hours.

There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the urgency of their health need. This information was also provided on the practice website and in the practice leaflet.

Comments received from patients on the day of the inspection showed that patients in urgent need of treatment had been able to make appointments on the

Good

Are services responsive to people's needs?

(for example, to feedback?)

same day of contacting the practice. They confirmed that they could see another doctor if there was a wait to see the doctor of their choice. We received four comments card which gave mixed feedback on the appointment system.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015 and found that 91% of patients described their experience of making an appointment as good, with 91% finding it easy to get through on the phone. These results were above average when compared to other practices in the Clinical Commissioning Group.

Listening and learning from concerns and complaints

We saw that information was available to help patients understand the complaints system. There was information on making a complaint in the practice patient information leaflet and on the practice website. Patients and their representatives, who we spoke with, were aware of the process to follow should they wish to make a complaint. None of the patients or their representatives had ever needed to make a complaint but they believed that any complaint would be taken seriously.

The practice had a system in place for handling complaints and concerns. Their 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. Following the receipt of a complaint, this was sent to the management team who allocated them to the relevant manager lead for investigation. We looked at four complaints received in the last twelve months. These had been acknowledged, investigated and a response had been sent to the complainant. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate.

The practice discussed and reviewed complaints at the clinical governance meetings in order to identify areas for improvement and shared learning. This was completed across all of the sites in order to maximise the shared learning.

We were told that themes and learning identified and completed as a result of complaints, were shared at a 'primary care group' meeting, on a six monthly basis. This group was made up of representatives from the patient participation group and clinical and managerial staff. This enabled external overview and scrutiny in relation to complaints. One of the recent themes identified was the restrictions with the phone line capacity for practice patients, as the practice also received calls for the other departments within the health centre. We were told by the head of people and governance that action was being taken to try and resolve this issue.

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 which was: 'To provide top quality healthcare to patients in a cheerful, relaxed, low stress environment by an efficient, amenable and accessible practice team who are well motivated, with a commitment to personal development.' All the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance Arrangements

The practice was led by the management team of Vida Healthcare. They had dedicated GP and managerial leads responsible for governance. In addition, there were clearly identified lead roles for areas such as complaints, safeguarding, education and information governance.

The practice held a monthly clinical governance meeting, where they discussed clinical governance issues including for example, updates from different areas of the practice, areas of risk, significant events and complaints. We looked at minutes from the previous meetings and found that performance, quality and risks had been discussed.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the shared drive. We looked at a number of these policies and procedures and found that most were up to date. The head of people and governance told us they were in the process of reviewing some of the policies. We noted that information about policies and procedures was part of the induction process for new staff. When policies and procedures were updated they were sent to staff electronically. There was a process for identifying when they had been read, so that the practice could identify those staff who had not read the updated information and ensure that they did.

The head of people and governance told us that they were in the process of reviewing a number of policies to ensure they were in line with those of Vida Healthcare. We saw that a number of updated policies were available on the practice shared drive and staff we spoke with knew where to find policies and guidance but also who they would obtain support and advice from if this was needed.

The practice sought external overview and scrutiny in relation to complaints and significant events. We were told that themes and learning identified and completed as a result of complaints and significant events were shared at a 'primary care group' meeting, on a six monthly basis. This group was made up of representatives from the patient participation group and clinical and managerial staff.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that QOF data was regularly discussed at clinical team meetings and plans were agreed to maintain or improve outcomes for patients. The QOF data for this practice showed it was performing in line with and above national standards.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control. Clinical staff also had lead roles in relation to their clinical expertise. There was a lead GP for a number of medical conditions, including for example asthma, diabetes and women's health. The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice for other areas.

We saw from the minutes we looked at that staff meetings were held regularly. We spoke with eight members of staff who told us that felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or clinical meetings as appropriate. There was a willingness to improve and learn across all the staff we spoke with. Staff told us they felt the leadership in place at the practice was consistent and fair and generated an atmosphere of team working.

Practice seeks and acts on feedback from users, public and staff

The practice had gathered feedback from patients through patient surveys, a patient's comments book and complaints. The practice had an active patient participation group (PPG) which met four to five times per year. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. The members of the PPG who we spoke with told us that they found the practice were open and answered questions directly and openly. For example, we were told that the practice shared the learning from complaints with the PPG.

Are services well-led?

Good

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

We saw that improvements had been made following feedback from the patient's survey completed in 2014. Further extended hours provision had been put in place on a Thursday to add to the Monday GP session in order to offer more convenient appointments for working patients. New play boards for children had been installed in the waiting room and more leaflets had been made available in a more accessible location for patients. The PPG representatives we spoke with told us that they felt able to express their views to the practice and that any suggestions they had for improving the service were taken seriously.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff were aware of how to raise suggestions and concerns and all of the staff we spoke with said that they would feel confident to do this and would be listened to. The practice had a whistle blowing policy which was available to all staff electronically, on the shared drive. All the staff we spoke with were aware of this policy, although they told us that they did not think they would need to use it. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

The practice had a culture which enabled learning and improved performance. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality, safe and effective care.

Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. In addition to their mandatory training they were supported to attend study days each year to undertake training in areas of their specialist interest. This enabled clinical staff to meet the revalidation requirements for their professional registration. We were told by a number of staff that the practice participated in 'time to learn' sessions quarterly. Training was arranged by the Clinical Commissioning Group (CCG) or training was undertaken within the practice according to the needs of the practice staff. We reviewed three staff files and saw evidence that both mandatory and training which was applicable to staff roles had been completed. We saw that regular appraisals had been undertaken which included a personal development plan.

The practice was a GP training practice and was involved in the training of GP registrars. GP registrars are qualified doctors who are undertaking further training to become GPs. There was a strong focus on clinical excellence and training and support for clinical staff. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

The practice had completed reviews of significant events and other incidents and complaints and shared with staff via meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment.