Cromer Group Practice

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 carried out an announced comprehensive inspection at Cromer Group Practice on 23 September 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 report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice undertook a wide range of both clinical and non clinical audits to drive improvements in patient care.
- The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG). Information about how to complain was available and easy to understand.
- There was a structured system for providing staff in all roles with annual appraisals of their work and planning their training needs.
- The practice was committed to primary care development and education. They took an active part in GP education and primary care research
- There was a clear leadership structure and staff felt supported by management.

We saw several areas of outstanding practice including:

- The practice provided a daily 'ward round' to a local nursing home. This service was greatly valued by both

Summary of findings

staff and residents at the home. Evidence from the clinical commissioning group showed that this had reduced the number of hospital admissions and referrals from the home as a result.

- In response to a complaint about the lack of information for bereaved patients, the practice had devised its own support leaflet , 'Coping with bereavement' which had been taken up by the CCG and shared for use by other local practices.

However there were areas of practice where the provider should make improvements:

- The practice should appoint leads for safeguarding, infection control and mental capacity and ensure these staff receive training at an appropriate level
- The practice should undertake an assessment of the risks in not carrying emergency medicines on patient home visits.
- The practice should ensure that all staff who undertake chaperone duties receive appropriate and effective training for this role. A risk assessment should also be completed if staff do not have a disclosure and barring check (DBS) in place, and are undertaking chaperone duties.
- The practice should assure themselves that any locum GPs recruited from an agency have the appropriate DBS checks in place.
- All treatment rooms should have privacy curtains around examination couches.
- The practice should restrict access to the dispensary to authorised staff only and implement measures to track prescription forms in accordance with national guidance.

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 was safe and is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report significant events or other incidents. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed and there were effective arrangements to identify and respond to potential abuse. The practice was clean and hygienic. Staff were recruited through processes designed to ensure patients were safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with empathy and respect by staff and 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. Information about how to

Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

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 and 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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice ran proactive vaccination campaigns and catch up programmes for shingles and pneumonia immunisation, along with an annual flu campaign.

The practice's clinicians provided a daily 'ward round' to a large local nursing home .

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice met all performance targets in relation to the management of long term conditions and offered specialist respiratory and anti-coagulation therapy clinics to patients. All patients had a named GP and a structured annual review to check that their health and medication needs were being met.

The practice's clinicians provided a daily 'ward round' to a local 18-bedded health care unit.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were relatively high for all standard childhood immunisations. Local midwives held weekly clinics at the practice and patients had post natal appointments with the GPs, All children who registered with the practice were referred to the health visitor. The practice offered contraceptive advice and implants.

The practice had recently extended the time for its immunisation clinics to allow extra time for its nurses to advise parents.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students).

Summary of findings

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. However it did not provide any extended opening hours.

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 carers and those with a learning disability, and carried out annual health checks for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children.

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 offered enhanced services for patients with mental health concerns and those with dementia. It regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

It had recently worked closely with the clinical commissioning group to improve communication between health care services about patients with a diagnoses of dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing in line with local and national averages, apart from its access by telephone. There were 139 responses and a response rate of 54.1%.

- 62% find it easy to get through to this surgery by phone compared with a CCG average of 78 and a national average of 74%.
- 85 % find the receptionists at this surgery helpful compared with a CCG average of 90% and a national average of 86%.
- 75 % with a preferred GP usually get to see or speak to that GP compared with a CCG average of 62% and a national average of 60%.
- 93% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 95% say the last appointment they got was convenient compared with a CCG average of 95% and a national average of 91%.
- 83% describe their experience of making an appointment as good compared with a CCG average of 78% and a national average of 74%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 47 comment cards which were all positive about the standard of care received. Patients reported that they were treated in a way they liked and described staff as empathetic, caring and professional. They particularly appreciated the on-line appointment booking service and being able to see their preferred GP. However, they also commented on difficulties with parking, a lack of seats in the waiting areas, and the limited opening times of the practice. Four people reported that the pharmacy service wasn't always good.

Areas for improvement

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Action the service SHOULD take to improve

- The practice should appoint leads for safeguarding, infection control and mental capacity and ensure these staff receive training at an appropriate level
- The practice should undertake an assessment of the risks in not carrying emergency medicines on patient home visits.
- The practice should ensure that all staff who undertake chaperone duties receive appropriate and effective training for this role. A risk assessment should also be completed if staff do not have a disclosure and barring check (DBS) in place, and are undertaking chaperone duties.
- The practice should assure themselves that any locum GPs recruited from an agency have the appropriate DBS checks in place
- All treatment rooms should have privacy curtains around examination couches.
- The practice should restrict access to the dispensary to authorised staff only and implement measures to track prescription forms in accordance with national guidance.

Outstanding practice

- The practice provided a daily 'ward round' to a local nursing home. This service was greatly valued by both staff and residents at the home. Evidence from the clinical commissioning group showed that this had reduced the number of hospital admissions and referrals from the home as a result.

Summary of findings

- In response to a complaint about the lack of information for bereaved patients, the practice had devised its own support leaflet , 'Coping with bereavement' which had been taken up by the CCG and shared for use by other local practices.

Cromer Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and a medicines optimisation inspector.

Background to Cromer Group Practice

Cromer Group Practice is a well-established GP surgery that has operated in the area for over 30 years. It serves approximately 13000 registered patients and has a general medical services contract with North Norfolk Clinical Commissioning Group (CCG). The practice's population rises sharply every summer with almost 1000 additional patients registering temporarily, whilst holidaying in the locality.

It provides medical services to a large number of care homes in the local area, and operates a dispensary. Compared with other practices nationally, it has a higher proportion of patients aged 60 years and above (31% of its total population group), and a lower proportion of patients 0-40 years.

The practice consists of five GP partners, four nurse practitioners, three nurses and three health care assistants. They are supported by a full time business and operations managers, and a number of reception and administrative staff. It is a training practice and offers placements to qualified doctors wanting to become GPs and medical students. It also offers placements to trainee nurses and pharmacists.

The practice is open between 8.30am and 6 pm Monday to Friday. It closes on a Tuesday between 1pm and 2 pm for staff training. Doctors consulting hours are Monday to Friday 9 am to 12 noon, and 2pm to 5.30pm. It does not provide extended hours opening.

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?

Detailed findings

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)

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 23 September 2015. During our visit we spoke with a range of staff including GPs, nurses, health care assistants and administrative staff . We also spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Staff told us they would inform the business or operations manager of any incidents and there was also a recording form available on the practice's computer system. We viewed a small sample of completed significant event forms and saw they had been completed in depth, clearly describing the event, the investigation following it and the action plan implemented to ensure it didn't reoccur. We viewed minutes of the partners' weekly minutes and saw that significant events were a standing agenda item to be discussed. Staff we spoke with also confirmed that significant events were discussed regularly at practice meetings. One health care assistant was able to tell of us of a recent significant event that had led to a change in how nebulisers were stored in the practice. In response to other significant events, the practice had developed a protocol to identify patients' visits that were missed, and also changed their work flow systems so that letters could not be filed without being initialled and actioned by a GP.

National patient safety alerts were disseminated to appropriate staff via email. However despite this, we found that the practice had failed to respond to an alert from the Medicines & Healthcare products Regulatory Agency in relation to the drug Ibuprofen. We outlined the potential risks to patients as part of our inspection feedback and the practice took immediate action to remedy the oversight. Following our inspection, every GP was signed up individually to receive these alerts, and the practice undertook a thorough audit to ascertain if it had missed any others. They sent us their new protocol which included the practice undertaking an audit of all alerts received every three months. We were satisfied that this prompt action would greatly minimise the risk of a similar event reoccurring.

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. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was also a whistleblowing policy of which staff were aware. We saw that contact details of relevant safeguarding organisations were easily accessible in each treatment room. Staff demonstrated they understood their responsibilities and all had received appropriate safeguarding training relevant to their role, although it was not clear how many of the practice's GPs had attained level 3 safeguarding training. Staff were not aware of who the safeguarding lead was within the practice and their knowledge about the external agencies involved in adult protection was limited.

There was a system to highlight vulnerable patients on the practice's electronic records and minutes we viewed showed that patient safeguarding concerns were discussed at some length at the partners' weekly meetings, with actions agreed to better protect patients. Midwives and health visitors attended the first part of the practice's clinical governance meetings to discuss any vulnerable patients.

Notices were displayed in the waiting area advising patients that they could request a chaperone. There was also information about the chaperone service on the practice's website. Male and female staff were available to provide chaperoning for patients when required. We were told that all staff who acted as chaperones had received training, but we found that their knowledge of what the role involved was variable. Not all staff who chaperoned had received a DBS check and there was no risk assessment in place to show the reason why the practice felt there was no need for one. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, following our inspection the business manager contacted us to inform us that she had applied for DBS checks for all reception staff and had implemented a new policy that checks would be renewed every three years for staff.

Risk

The practice's operations manager was responsible for all risk assessing within the practice had undertaken suitable training for this role. We viewed a risk assessment register that outlined all the assessments in place at the practice and the date they had last been reviewed. These were wide ranging and covered a range of risks to both patients and staff including those for taking blood, using the microwave, slips, trips and falls, and violence at work. There was an up

to date fire risk assessment and regular fire drills were carried out. However we found that the risk of clinicians not carrying emergency medications on home visits had not been assessed. In addition to this the practice did not have trained lead roles for safeguarding patients, for infection control and for mental capacity which indicated a gap in the practice's overall risk management system.

Staff Recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of staff's identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, staff who had worked at the practice for a number of years had not received a DBS check and the practice did not hold a copy of the DBS check for the locum doctor who was employed.

One staff member who had recently been recruited told us her recruitment had been thorough and she had been interviewed by the business manager, operational manager and a senior member of the reception team.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs and the business manager showed us a recent staffing analysis she had undertaken to review the skills mix within the practice to ensure patients' needs could be met.

Infection Control

The practice employed its own cleaners and we viewed detailed daily, weekly and monthly task sheets for them to complete. The practice's operations manager undertook weekly cleanliness checks to ensure standards were maintained. However there was no identifiable lead for infection control within the practice

We observed that all areas of the practice were visibly clean and hygienic, including the waiting area, corridors, meeting rooms and treatment rooms. 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 noted one treatment room was carpeted, however staff told us that minor surgery was never undertaken in this room. We also noted that labels on sharps' bins had not been completed and hand washing sinks did not meet current best practice guidelines.

We viewed waste notes that showed the practice dealt appropriately with clinical waste. The practice had completed a risk assessment for legionella (a bacterium which 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 were undertaken we viewed details of the most recent one conducted on 17 July 2015. As a result of this, the practice had purchased new disposable privacy curtains, added the cleaning of fridges to the cleaners' task list and also updated their polices.

Medicines Management

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and reflected current practice. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality dispensing services to patients. The practice had conducted some audits of the quality of its dispensing services, however, we were told more had been planned during 2015-16. Patients we spoke with told us they received an efficient dispensing service run by pleasant and helpful staff. Dispensary staffing levels were in line with DSQS guidance. Staff involved in the dispensing of medicines had attained suitable qualifications and had been assessed as competent for their role.

We noted the arrangements in place for patients to order repeat prescriptions. The practice had established a daily delivery service for patients who had difficulty collecting their prescriptions and a service for patients to pick up their dispensed prescriptions at alternative locations. The practice had systems in place to monitor how these medicines were collected. Prescriptions were reviewed and signed by a GP before they were given to the patient. The dispensary where medicines were stored was well organised and medicines were stored securely. However,

additional measures were needed to ensure the dispensary was only accessible to authorised staff. Blank prescription pads were kept securely, however, improvements were also needed to track blank prescription forms through the practice in accordance with national guidance.

There were regular practice meetings to discuss significant events including when there were prescribing incidents or dispensing errors. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Dispensing errors were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

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 Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery.

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. Appropriate action was taken based on the results. The practice had a prescribing lead who attended local clinical commission group meetings and reported back to practice colleagues.

The practice had identified it had a slightly higher than average hypnotic prescribing levels and audited their hypnotic prescribing, leading to 20 patients being supported to manage their condition in a safer and more effective way.

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 regularly and we saw maintenance logs and other records that confirmed this. We saw evidence of the calibration and service of relevant equipment; for example weighing scales, oxygen monitors and vaccine fridges. We also viewed a detailed inventory list detailing all equipment the practice held.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and there were emergency medicines available in the practice. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However we noted that the defibrillator pads were out of date and therefore not safe to use, and staff did not practice emergency simulations to ensure they knew what to do in the event of an emergency. 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, but there was no system in place to check these regularly and ensure they were within date and fit for use. However, following our inspection the business manager informed us she had ordered new defibrillator pads and sent evidence of an emergency trolley audit and checking system she had implemented.

The doctors did not carry any emergency drugs on home visits for example, penicillin for meningitis or aspirin for heart attacks. No assessment of the risks to patients for this had been completed.

An emergency panic button was available in treatment rooms so that clinicians could summon assistance in an emergency.

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 and copies were held off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. Any new NICE guidance was downloaded and put in a folder for clinicians to sign that they had read it. A weekly clinical newsletter from North Norfolk CCG was circulated to all clinicians outlining any new NICE guidance and any updated local protocols and policies. These were discussed at the weekly clinical meetings so that clinicians were kept up to date. We viewed recent minutes which contained evidence of NICE guidelines in relation to diabetes and obesity being discussed.

The nurses met with one of the GP partners every two months where protocols were discussed.

One of the practice's health care assistants told us she regularly attended a respiratory educational group which helped keep her up to date with the latest guidance and treatments.

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. The practice had also been pro-active in identifying patients with potential dementia and had improved its dementia detection rates as a result.

Management, monitoring and improving outcomes for people

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. This is a system intended to improve the quality of general practice and reward good practice). Specific staff were responsible for overseeing the practice's QOF performance and we saw that QOF data was discussed at practice meetings. Figures given to us by the practice (which have to be validated) indicated that it had achieved 100% of the total number of points available for 2014/15, and had improved its performance from the previous year.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We viewed completed audits in relation to anticoagulation and atrial fibrillation therapies. Clinical audits were often linked to medicines management information. For example, working with the CCG prescribing advisor the practice audited its hypnotic prescribing, leading to a reduction in their usage. At the time of our inspection the practice was auditing its oral contraceptive prescribing. The driver for this was finding a patient aged under 35 years with high blood pressure. The first cycle of the audit had been completed, leading the practice to change its contraceptive template on its clinical system. The practice also actively took part in research, participating in studies about stroke prevention and chronic fatigue syndrome.

A good range of non-clinical audits were also completed to drive improvements in patient care and the business manger told us of audits in relation to how reception and the telephone system operated. As a result of the telephone audit, additional staff were employed to answer calls in the morning.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. It also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. A dedicated phone line was available for care homes if they needed to discuss possible hospital admissions for their residents. Emergency hospital admission rates at 14.8% for the practice were comparable to the national average of 14.4%.

Structured annual reviews were also undertaken for people with long term conditions and data we viewed showed that 94% of diabetic patients had an annual review during 2014-5, and 92% of COPD patients had an annual review.

Effective staffing

The practice had coped well in response to significant staff challenges recently, with locums and nurse practitioners

undertaking additional shifts to cover staff absences. The practice had a very good skills mix which included four advanced nurse practitioners who were able to see a broader range of patients than the practice nurses. In addition to this, a specific respiratory nurse was employed two days a week, and three health care assistants who could undertake a range of patient health checks. At the time of our inspection, the practice was reviewing the skills mix within the clinical team to ensure it better met patients' needs. The business manager showed us a very detailed staffing analyses she had undertaken to increase the number of nurse appointments available to patients, and improve the service to housebound patients.

All staff received training that included: safeguarding patients, fire safety, basic life support, conflict resolution infection control and information governance awareness. Staff had access to, and made use of, e-learning training modules and in-house training. We found staff to be knowledgeable and experienced for their roles.

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. We viewed the practice's appraisal register which showed that all but five staff had received an annual appraisal within the last 12 months. Staff told us they found their appraisal useful as it helped them identify their key achievements and training needs. The nurse practitioner and GPs regularly sat in on each other's clinics for assessment and training purposes.

Coordinating patient care and information sharing

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

The practice had also signed up to the electronic Summary Care Record and used them effectively to meet the needs of its many temporary patients during the summer months. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The business manager attended the local CCG's council of members and also attended peer practice manager group meetings to share knowledge and best practice with neighbouring practices.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings took place on a two monthly basis and that care plans were routinely reviewed and updated.

The practice had strong links with care homes in the local area and provided a daily 'ward' round to Halsey House each day. One of the GPs provided medical cover at Benjamin Court, an 18 bedded health care unit. Staff from these settings told us that the practice's clinicians worked well with them to improve their residents' health and well being.

Patients with learning disabilities or dementia were given a hard copy of their care plans so that they could take it with them when attending hospital or other health care settings, ensuring that these services received accurate information about their health needs.

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 of the nurse practitioners worked closely with a local nursing home to ensure residents living there had advance care planning in place. Clinical staff also demonstrated a good knowledge of deprivation of liberty safeguards for residents living in the care homes they supported.

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 contraceptive device fitting.

Good

Are services effective?

(for example, treatment is effective)

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.

Patients had access to appropriate health assessments and checks. These included health checks for new patients, for 15 and 16 year olds and for people aged between 40–74 years. The practice also offered health checks for patients with a learning disability (LD) and had provided health checks for 51% of these patients: 100% of patients had been invited to attend. The practice had devised a LD review template for these health checks in conjunction with the local LD community team.

There were a number of staff trained in smoking cessation, and one of the practice's nurses told us that about 50% of patients who attended these sessions were successful in quitting smoking. The practice provided a full family planning service including the fitting of contraceptive devices.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81%, which was comparable to the national average of 82%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94% to 100 % and five year olds from 87% to 95%. Flu vaccination rates for the over 65s were 76%, and at risk groups 55%. These were slightly higher than CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from the 47 comment cards we received was very positive about the way patients were treated by the practice's staff. Respondents told us that staff were caring and professional, and took their health concerns seriously. The GPs ran personal lists, allowing them to get to know their patients and patients receiving good continuity of care. Patients told us they particularly valued this.

We spoke with a number of care home managers who told us that the GPs and nurses worked empathetically and patiently with their residents, especially those living with dementia . One particular GP was praised for the effective way he communicated with people with learning disabilities.

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. We noted that staff were rigorous in removing their smart cards when leaving their desks to ensure confidentiality. However the reception area was not particularly private and telephone calls taken by receptionists could be easily overheard by patients waiting at the desk. We noted that there were not enough chairs available in the waiting area and at busy times of the day, patients had to stand whilst they waited for their appointment. This also occurred in the dispensing area.

We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However privacy curtains were not provided in two of the consulting rooms that we viewed to help maintains patients' privacy and dignity during examinations.

Results from the national GP patient survey showed patients were generally happy with how they were treated by the practice's staff. The practice was comparable to other practices for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% said the GP was good at listening to them compared to the CCG average of 91% and national average of 87%.
- 87% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 98 % said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 88% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 95% and national average of 90%.
- 85% patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

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 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.

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:

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% 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 85% and national average of 81%.

Patient and carer support to cope emotionally with care and treatment

The practice had a specific carers' protocol and a poster and registration form asking carers to identify themselves. Each carer that was identified was given a 'Carers Pack' which contained a copy of the Norfolk Carers' Handbook for 2014-2015. This provided good information about local support groups, respite services, carers' rights and carers assessments.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them. There was useful information on practice's website-'In times of bereavement'- advising patients about what to do when a death occurred at home and the practice had developed in its own bereavement information leaflet for patients. We viewed the practice's compliments folder and saw many commendations and thanks for the good palliative care and support it provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area and the business manager was a member of the council of members for the CCG. She told us the practice is hoping to work closely with the CCG to try and implement a local weight management service. The practice's performance lead had recently worked with the CCG on a project looking at dementia diagnosis rates, and how the Mental Health Trust informed GP practices about patients diagnosed with dementia. This had resulted in improved communication across the CCG, Mental Health Trust and GP practices about patients with dementia.

The practice had a high number of temporary residents with almost 1000 registering each year, especially in the summer months. As a result it ensured there were additional locum staff available at this time to maintain a good level of service to patients.

The practice offered a wide range of services to patients in addition to chronic disease management including NHS health checks, family planning (including contraceptive implants and coils), smoking cessation, vaccinations and travel advice. It also participated in an enhanced service to actively monitor the weight of, and support patients with, an eating disorder. The practice was very keen to increase the number of services it offered and also its clinical team, but was greatly constrained by the lack of consulting rooms in its current premises.

One of the Nurse Practitioners provided a daily 'ward round' to a large local nursing home. The manager there told us of the excellent service she received from the nurse and reported it had greatly reduced the number of hospital admissions and referrals to other services.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example, there were longer appointments available for people with a learning disability or patients who were homeless; and urgent access appointments were available for children and those with serious medical conditions. There were male and female GPs in the practice allowing patients see a GP of their preferred gender. Respiratory patients had a home visit each year for disease management and the practice was reviewing how it might be able to offer this service for other patients with chronic diseases.

There were disabled toilet facilities and a hearing loop available which was shared with the pharmacy. Although there was level access to the premises, there was no automated opening front door, or lowered counter area at reception, making it difficult for wheelchair users. The waiting area was small with reduced turning ability for scooters.

The practice held food bank forms to give to patients who were struggling financially.

Access to the service

The practice was open between 8.30am and 6pm Monday to Friday. Appointments were from 9am to 12 noon every morning, and 2pm to 6pm daily. A duty GP was available daily to see emergencies and all but three appointment slots each day were held for urgent appointments. A 'sit and wait' service was available to patients each day from 11.30am to 12.30pm. We visited on 23 September 2015: the next routine appointment was available on 24 September 2015 with a nurse practitioner, and on 25 September with a GP.

The practice did not offer any extended hours surgeries, and three patients told us they found it difficult to attend during working hours. Results from the patient participation groups' survey showed that appointments were difficult to book on the telephone, which also aligned with the results of the national GP survey.

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. A text service was available to remind patients of their appointment times. The business manager reported the practice had been working hard to reduce the number of patients who did not attend appointments and had reduced these successfully from 80 to 40 hours a month.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mostly comparable to local and national averages and or example:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 73% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 62% patients said they could get through easily to the surgery by phone compared to the CCG average of 78% and national average of 74%.
- 82% patients described their experience of making an appointment as good compared to the CCG average of 78% and national average of 74%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system with good information available in the waiting area and on the practice's web site. The practice's patient information leaflet gave the name of the person responsible for managing complaints and also the address of NHS England for patients who did not want to contact the practice directly. Reception staff spoke knowledgeably about how to manage complaints and the practice's procedure.

We looked at the practice's complaints log since October 2014 and found that appropriate action had been taken to address the concerns raised. Lessons were learnt from patients' complaints and action was taken to as a result to improve the quality of care. For example, following a complaint about the lack of information for bereaved relatives from a patient, the practice had developed a bereavement leaflet that was sent to the complainant for approval. The complainant was so pleased at this that they wrote to the local MP and CEO of the CCG praising the practice. Following this, the CCG wrote to the practice requesting that the leaflet be used in other GP practices. Another complaint in relation to the processing of a urine sample, had resulted in the practice's urine testing policy being rewritten.

The practice regularly responded to patients' comments received on the NHS Choices web site.

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 of providing care 'with traditional values combined with best medical and administrative practice' and this was clearly stated to patients on its website. We viewed the practice's business development plan for 2015-2018, which clearly outlined the changes it proposed to make in the next three years. This included increasing the role of the patient participation group,; moving to new premises and increasing the use of additional technology within the practice. A number of staff spoke of recent improvements to the practice and of the proposed move to more suitable premises, stating that this would bring many benefits both to patients and the practice.

Governance arrangements

There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The practice had a business manager who was responsible for the day to day running of the practice. She was supported by an operations manager, performance lead and finance lead. Each of the practice's partners took it in turn to be an executive lead for a six month period. One of the partners took responsibility for supervising the work of the nurses, and another supervised the work of the nurse practitioners and health care assistants. Supervision of other staff was divided between the business manager, operations manager and performance lead. Staff told us this system worked well.

The practice had a full range of policies and procedures in place to govern activity and these were available to staff on the practice's computer systems. We viewed a spread sheet with a list of all the practice's policies and procedures with last and next review dates. Although some of these policies had not been reviewed recently, staff were aware of this and working through them to ensure they remained relevant and accurate.

Communication across the practice was structured around key scheduled meetings. There were weekly partners' meetings, and the business manager and executive partner met once a week. Clinical governance meetings were held once a month, and the business manager along with two partners met with the pharmacist once a month. All partners met informally every morning at 8.30 am to discuss the day ahead and any issues that had arisen. We found that communication systems across the practice and between staff were effective.

The practice was pro-active in identifying potential risks and challenges to its business.

We viewed a comprehensive and wide ranging risk log which covered all potential risks to the practice. This included moving to the new premises, the effects of paying staff the new national minimum wage, and staff ill-health and maternity leave. Each risk had been rated and regularly reviewed.

Leadership, openness and transparency

We found that the partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. We received particularly good feedback about the practice's business manager, and both the practice's staff and external stakeholders told us of the many positive changes she had implemented since starting her role. She had introduced a staff appraisal system and fire evacuation drills, and had strengthened procedures in relation to significant event management and complaints handling. We found her to be responsive and proactive in addressing some of the shortfalls we identified during our inspection, many of which had been resolved a few days later. She was enthusiastic about her work and clearly committed to improving the service for both patients and staff.

Staff told us there was an open culture within the practice and they were encouraged and confident to raise any issues at any time. These were discussed openly at staff meetings where relevant and it was evident that the practice worked as a team and dealt with any issue in a professional manner. For example, we viewed minutes of a practice meeting where the business manager shared with staff how the practice was funded and some of the challenges it faced with funding in the future. This was also evident when we looked at the complaints and compliments they had received in the last 12 months and the actions that had been taken as a result. A member of

Are services well-led?

Good

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

the patient participation group (PPG) told us that patients' complaints were a standing item on their meeting agenda and that staff were open and honest about the way the practice was run.

The practice had openly shared a recent staffing issue with NHS England and the CCG.

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

The practice encouraged and valued feedback from patients, and had worked hard in the last year to strengthen the role of the PPG and also increase its membership. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, in response to suggestions from the PPG, the practice now opened its doors 10 minutes earlier in the morning, so that patients could book themselves in before the clinics began. It had also increased the number of reception staff available in the morning to cover telephone bookings for appointments. One of the PPG's members told us that members had been actively consulted and asked about ideas for the practice's new premises.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Patient responses had been low but the practice was working with the PPG to increase their number. The most recent results showed that 19 patients were extremely like to recommend the practice, 1 patient was likely to and 1 patient was extremely unlikely to recommend it.

The practice had also gathered feedback from staff through regular staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and managers. Staff told us their suggestions to improve and develop the service were listened to by the partners. For example, the operations manager told us his suggestion to introduce a texting service for patients had been implemented. A nurse told us her ideas for making the new build premises dementia friendly had been taken on board by partners, and a health care assistant told us her suggestion about the safe handling of urine bottles was being considered. We noted a 'suggestions and grumbles' box in the staff room.