Dr J K Mathews and Partners

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?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at DR J K Mathews and Partners on 3 November 2015. Overall the practice is rated as good.

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

- The practice offered a wide range of services to meet patients' needs
- The practice had a very good skill mix which included advanced nurse practitioners who were able to see a broader range of patients than the practice nurses.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients and staff were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance a clinical staff had the skills, knowledge and experience to deliver effective care and treatment. However there was no formal system in place to ensure that clinicians were kept up to date with the latest guidance.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The was one where the provider must make improvement:

Summary of findings

- Ensure that only trained staff who have been risk assessed regarding the need for a DBS check undertake chaperone duties. Ensure that a sign is clearly on display in each consulting or treatment room offering chaperone service if required.

The areas where the provider should make improvement are:

- Ensure there is a system is in pace to monitor that all relevant medicines and healthcare product regulatory safety updates are actioned.
- Produce written protocols on how to deal with patients on high risk medicines, especially those who have not attended for a blood test.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Improve the training for reception and administrative staff to ensure they have the knowledge and skills for their role.
- Keep a record of recruitment interviews conducted with all potential employees

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice. Safeguarding procedures were good and risks to patients were assessed and well managed. Patients received care in an hygienic and clean environment. However, we found that Medicines and Healthcare products Regulatory Agency updates were not being consistently actioned and that not all staff who chaperoned had received a DBS check.

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 assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement. Staff had the skills, knowledge and experience to deliver effective care and treatment. 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 compassion, dignity and respect and that they were involved in decisions about their care and treatment. Information for patients about the services available was accessible and easy to understand

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice offered a wide range of services and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity

Summary of findings

and held regular governance meetings. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on, and the patient participation group was active.

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 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. It provided additional checks at flu clinics for patients aged 65 and over to identify possible atrial fibrillation.

The practice had built up effective relationships with the care homes it provided services to, and had a named contact within the practice to process medicines administration records for patients living in these homes.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs worked with relevant health and care professionals to deliver a multidisciplinary care package to patients with the most complex needs. Nursing staff were experienced and well trained in chronic disease management, and patients at risk of hospital admission were identified as a priority. The practice provided diabetic retinopathy and warfarin screening clinics. There was an efficient and effective recall system in place.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice offered a wide range of family planning advice and treatment to all age groups. There was a chlamydia screening service for 15-24 year olds and weekly midwife clinics at the practice. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Summary of findings

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. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. People with learning disabilities were offered annual health checks and there was a learning disability lead within the practice.

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). Patients with significant mental health problems had annual mental health and medicines reviews, and many had their own care plan in place. The practice provided patients with a list of low cost counselling services in the area.

The practice participated in the proactive identification scheme for patients with dementia and

88% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. It was working with a specialist to improve its dementia detections rates in patients.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 The results showed the practice was performing in line with local and national averages. 257 survey forms were distributed and 127 were returned.

- 92% found it easy to get through to this surgery by phone compared to a CCG average of 73 % and a national average of 73%.
- 94 % found the receptionists at this surgery helpful (CCG average 87%, national average 87%).
- 95 % said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 86 % described their experience of making an appointment as good (CCG average 74%, national average 73%).
- 72 % usually waited 15 minutes or less after their appointment time to be seen (CCG average 65%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 completed comment cards and most respondents were positive about the standard of care received. A community physiotherapist praised the attitude, skill and empathy of one of the practice's doctors having accompanied a patient with learning disabilities to a consultation. However two people stated that the GPs often ran late, which meant they had to wait a long time.

We spoke with six patients during the inspection. All six patients said that they were happy with the care they received and thought that staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

Ensure that only trained staff who have been risk assessed regarding the need for a DBS check undertake chaperone duties. Ensure that a sign is clearly on display in each consulting or treatment room offering chaperone service if required.

Action the service SHOULD take to improve

- Ensure there is a system is in pace to monitor that all relevant medicines and healthcare product regulatory safety alerts and updates are actioned
- Produce written protocols on how to deal with patients on high risk medicines, especially those who have not attended for a blood test.
- Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines
- Improve the training for reception and administrative staff to ensure they have the knowledge and skills for their role.
- Keep a record of recruitment interviews conducted with all potential employees

Dr J K Mathews and Partners

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 advisor, and a practice manager specialist advisor.

Background to Dr J K Mathews and Partners

DR J K Mathews and Partners is a well-established GP surgery that has operated in the area for many years. It serves approximately 10,000 registered patients and has a general medical services contract with NHS Norwich Clinical Commissioning Group. It is located in a reasonably affluent area of Norwich.

According to information taken from Public Health England, the patient population has a higher than average number of patients aged 55-85 years, and a lower than average number of patients 1-44 years compared to the practice average across England. There is a high prevalence of asthma, cancer, heart failure and stroke amongst its patient population compared to national average.

The practice consists of eight 4 male GP partners, two nurse practitioners, four nurses and one health care assistant. A number of reception and administrative staff support them. It is a teaching practice involved with the training of GPs and medical students.

The practice is open between 8.30am -6pm Monday to Friday only, and does not offer any extended hours opening times.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. The 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.

How we carried out this inspection

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 3 November 2015. During our visit we spoke with a range of staff including GPs, nurses and administrative staff and reviewed patient treatment records. We also reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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)

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. They also reported that any significant events relevant to them would be shared at the appropriate meetings. We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. For example, we reviewed the partners' meeting minutes for 8 July and saw that a significant event concerning a delay in the result of a urine sample being seen was discussed with those present.

Lessons were shared to make sure action was taken to improve safety in the practice. For example, one serious incident resulted in the practice purchasing diazepam ampules to use in a syringe driver. Following a safeguarding incident, the practice's protocol had been up dated and circulated to all staff, to ensure a similar incident would be managed differently in the future, and both the practice's own safeguarding lead and the CCG lead would now be informed. We viewed minutes of a partners' meeting on 12 August where this new policy about handling safeguarding allegations was discussed with staff.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). We were informed that the practice manager received them and then disseminated them to the GPs. However, the practice could not demonstrate to us it had responded to MHRA safety updates about the medicines hydroxyzine and ibuprofen, and we could not be assured that potential risks to patients' safety were being addressed.

Overview of safety systems and processes

Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements, and safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP within the practice for safeguarding who attended clinical commissioning group (CCG) led safeguarding meetings with leads from other practices. The practice manager was in the process of setting up regular meetings with the local health visitor to review any children and young people on the practice's safeguarding list . Patients with any safeguarding concerns were highlighted on the practice's computer system so that clinicians were aware of any concerns. The practice manager had instigated a monthly audit of children who did not attend appointments so that these could be monitored closely and referred to the lead safeguarding GP if concerns were identified.

Staff had appropriately reported a safeguarding incident that had occurred within the practice both to us and the deanery.

A notice in the waiting room advised patients that chaperones were available if required. However, notices were not available in the treatment rooms where patients would be more likely to see them. Chaperoning was usually provided by one the practice's nurses. We were told that reception staff occasionally undertook chaperoning duties. However some of these staff had not received any training for this role and a risk assessment had not been undertaken to establish whether a disclosure and barring check (DBS) was required. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. The practice manager assured us he would take immediate action to ensure only trained staff with appropriate DBS checks in place would chaperone.

Infection Control

Patients who completed our comment cards told us that they were happy with the standards of hygiene and cleanliness at the practice. The practice had a named lead for infection control and also conducted its own comprehensive infection control audits, evidence of which we viewed. It also conducted general cleanliness audits, the most recent of which had led to the employment of a new cleaning contractor. Infection rates following minor surgery were monitored closely and the most recent audit showed there had been no infections.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting areas, 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 posters providing prompts above

each sink reminding staff of the correct way to wash their hands. We saw that sharps boxes had been assembled and labelled correctly. There were foot operated bins and personal protective equipment available in each room to reduce the risk of cross infection. However some consulting rooms had carpets on the floor, and privacy curtains around treatment couches were not disposable. This was not in line with good infection control guidance but the practice had completed a risk assessment and limited the types of procedure undertake in these rooms to reduce the risk.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients

Clinical waste was stored securely in locked bins outside the practice, within an locked gated area. Signage was clear and in view of anyone approaching the area..

Clinical staff had received appropriate inoculations against the risk of Hepatitis B.

Medicines management

The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). However we found that there was no clear protocol in place to demonstrate how the practice dealt with patients on high risk medicines such as methotrexate, but who had not attended for a blood test.

Staff were able to describe to us appropriate arrangements for maintaining the cold-chain for vaccines following their delivery to the practice. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. There was a specific named contact in the practice for the processing of medication administration records for residents in the care homes it supported.

The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

The practice's prescribing rates were also similar to national figures for hypnotics, antibiotics and antibacterials.

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

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, spirometers, pulse oximeters and nebulisers.

Staffing and Recruitment

We reviewed four personnel files and found that appropriate recruitment checks had been undertaken prior to staff's employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Staff who had worked for the practice for many years had not received a DBS check but the practice manager told us that all non-clinical staff recruited since March 2015 had received a DBS check. The practice did not keep a formal record of the interviews with potential candidates to demonstrate they had been conducted in line with good employment practices.

All new staff underwent an induction to their role, and we spoke with a newly recruited member of staff who described their induction as 'excellent'. It had involved spending a full day working alongside a range of staff including the GPs, the health care assistant and reception staff.

Staff told us there were enough of them to maintain the smooth running of the practice and that there were always enough staff on duty to keep patients safe. The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement

Requires improvement

Are services safe?

in place for members of staff, including clinical and administrative staff, to cover each other's annual leave. Succession planning was in place to manage the potential retirement of two of the partners.

Monitoring risks to patients

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. We viewed comprehensive risk assessments in relation to legionella management, fire safety and potential hazards identified in the practice's building and environment. Regular checks of the building and its environment were completed to ensure both staff and patients were safe. The practice also had a health and safety policy and information was displayed for staff to see. We viewed a range of paperwork in relation to health and safety including asbestos management, electrical installation, emergency lighting and first aid, which showed that the practice maintained a safe environment for staff and patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies and there was an on-call GP on duty throughout the day. Records showed that all staff had received training in basic life support. Emergency equipment including oxygen and automated external defibrillators (used in cardiac emergencies) were available in the practice. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly by nursing staff. We saw that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff and all staff knew of their location. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was an instant messaging system on the computers in all the consultation and treatment rooms that alerted staff to any emergency

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice such as the loss of premises or electricity, or the death of a GP.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of, and worked to, guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment.

Clinicians told us that they were signed up to receive NICE alerts, and were responsible for keeping themselves up to date with best practice. We saw minutes of partners' and nurses meetings which showed that guidance was discussed and implications for the practice's performance and patients were identified. However, there was no formal system in place to ensure that NICE guidance had been disseminated effectively to staff.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.9% of the total number of points available. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed;

- Performance for diabetes related indicators was at 95.3%. This was 3.8 percentage points above the CCG average, and 5.5 percentage points above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100%. This was 0.3 percentage points above the CCG average, and 2.2 percentage points above the national average.
- Performance for mental health related indicators was 96.2%. This was 1 percentage points above the CCG average and 3.4 percentage points above the national average.
- The dementia diagnosis rate was 100%. This was 3.8 percentage points above the CCG average and 5.5 percentage points above the national average.

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. Personalised care plans had been developed for these patients to improve the quality and co-ordination of their care.

Emergency hospital admission rates for the practice were slightly higher at 20% compared to the national average of 14% . The practice manager attended a monthly meeting with the community matron and integrated care manager to discuss all patients discharged from health care settings in the previous month.

The practice had noted that its dementia prevalence rates were below nation averages despite having a high elderly patient population so was working with an Admiral Nurse (specialist dementia nurses) from Age UK to improve its detection rates.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

We were shown three clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, it had undertaken a review of its bisphosphonates (a drug used in the treatment of osteoporosis and similar diseases) prescribing to ensure that all patients within the practice who took them were being monitored in line with current guidelines. After the first audit cycle it found that only 40% of patients had been referred to a falls clinic or for physiotherapy. The second audit in May 2015 had found that this had risen to 69% of patients. The audit was planned to be repeated in a year. An audit of patients with possible atrial fibrillation found that 58% had been incorrectly coded. As a result all were then coded correctly and flagged for a review of their anticoagulation therapy.

Non-clinical audits were also completed to drive improvements in patient care and we viewed a range of audits including those for the quality of cleaning, post-operative wound infection rates, and for the non-attendance of children at appointments. It also participated in applicable local audits and research. For

Good

Are services effective?

(for example, treatment is effective)

example it had participated in a CCG review of the appropriateness and quality of their patient referrals for plastic surgery, and in the a Norfolk Diabetes Prevention Study.

Effective staffing

Despite some staffing challenges in the previous year to our visit, the practice had managed to maintain an effective service to patients. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits, and an additional nurse practitioner had been employed to meet patients' needs. A GP buddy system was in place to cover absences. The practice had an appropriate skill mix which included two nurse practitioners who were able to see and treat a broader range of patients than the practice nurses. All the nurses had a lead role in specific chronic diseases such as diabetes, asthma and wound care and were able to provide expertise and experience around this. The nurses attended a local forum for practice nurses, and two attended the Norfolk Respiratory Interest Group

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

Clinicians told us they were supported in their training and professional development. A registrar told us they had attended a recent 'Hot Topics' GP Course to keep their skills and knowledge up to date, and the practice was supporting one of the nurse practitioner's to complete a Masters Degree Advanced Practice. This nurse told us that as she was new to the practice, she also received clinical supervision every day from the lead nurse which she greatly valued. Although reception staff had completed essential training such as basic life support, equalities and diversity, mental capacity, and safeguarding patients, they had not received additional training in issues such as customer care, information governance and dementia to further enhance their skills.

There was a structured system for providing staff in all roles with annual appraisals of their work and for planning their training needs. Staff we spoke with told us they found their appraisal useful.

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 investigation and test results. Information such as NHS patient information leaflets were also available.

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Staff described to us a robust system for ensuring that all urgent two week wait referrals had been received by the relevant health setting. The practice had implemented Summary Care Record for patients. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency.

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. One of the GPs chaired the monthly integrated case management meetings, attended by social workers, district nurses and the community matron. We viewed minutes of these meetings which showed that patients' needs had been discussed in depth to ensure a comprehensive multiagency community approach to their care.

The practice provided GP care to older people living in four local care homes. Representatives from these care home confirmed that the practice worked with them in a supportive and helpful way.

Consent to care and treatment

Patients we spoke with told us that they were provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

All the clinical staff we spoke with understood the key parts of Mental Capacity Act (MCA) legislation and were able to describe how they implemented it in their work. For

Good

Are services effective?

(for example, treatment is effective)

example, one nurse showed a good understanding of the consent and best interest issues involved when treating patients with dementia or those with learning disabilities. She also showed a good awareness of the importance of gaining the correct parental consent when giving children their vaccinations. One of the practice's lead nurses had attended recent training on the MCA and had shared her learning with the practice's staff

We viewed a small sample of patients' records for those at the end of their life, and noted that their wishes concerning preferred place of death and whether or not they wanted to be resuscitated had been recorded so that they could be respected by staff. Patients' active consent to their minor surgery had been recorded on their notes.

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.

Care home representatives told us that the most of the practice's GPs were good at involving families in important resuscitation decisions for their residents who could not make those decisions for themselves.

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 a wide range of health and care topics and there were leaflets in the waiting rooms, giving patients information on a range of medical conditions. The practice provided a number of services on site including weekly smoking cessation clinics and a condom service. It was also able to make referrals to weight management support groups to help patients to achieve healthy living goals.

Patients had access to appropriate health assessments and checks. These included health checks for people aged 40–74 years and figures given to us by the practice showed that 400 patients in this age group had received an annual health check since April 2015.

The practice also offered health checks for patients with a learning disability. The practice had 63 people with a learning disability on its register, and had already completed 59 checks since February 2015. The practice used the Cardiff Health Check for People with a Learning Disability - a recognised and comprehensive tool to assess the health care needs of this group.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82%.Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98% to 100 % and five year olds from 95 % to 99%.

Flu vaccination rates for the over 65s were 74%, and at risk groups 47%. These were also comparable national averages. The practice also offered screening for atrial fibrillation when patients attended for pneumococcal and shingles vaccination

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spent time in the waiting and observed a number of interactions between the reception staff and people coming into the practice. Overall, the quality of interaction was good, with staff showing empathy and respect for patients who did not wait long to be seen. Some clinicians called through patients into consulting rooms in person, and in a friendly and professional manner.

Telephones on the front reception desk were used for internal communication between the practice's staff, whilst phones that were used to make and receive calls from patients were located in an closed office behind reception to ensure their confidentiality. We viewed a poster informing patients that if they wanted to discuss sensitive issues a private room could be made available. Staff told us that radio music could be played in the waiting area to prevent conversations being overheard between reception staff and patients.

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 curtains were not provided in all treatments and consultation rooms to maintain patients' privacy and dignity during examinations.

Patients we spoke with during our inspection reported that most staff treated them with respect and empathy. We received consistently good feedback both from the patients we spoke with, and the comment cards we received, about the helpfulness of the practice's reception staff.

Results from the national GP patient survey showed patients felt they were treated well by the practice's staff. The practice was in line with the average for its satisfaction scores on consultations with doctors and nurses. For example:

- 85 % said the GP was good at listening to them compared to the CCG average of 89% and national average of 87%.
- 87 % said the GP gave them enough time (CCG average 89%, national average 87%).
- 94 % said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 85% said the last GP they spoke to was good at treating them with care and concern (CCG average 85%, national average 85%).
- 89% said the last nurse they spoke to was good at treating them with care and concern (CCG average 89%, national average 90%).
- 94% said they found the receptionists at the practice helpful (CCG average 87%, national average 87%)

Care planning and involvement in decisions about care and treatment

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. We spoke with the managers of two local care homes who knew the practice. They told us that the GPs who visited involved residents in decisions about their care and were also good at listening to, and consulting with, their staff about the best way to manage residents' health needs.

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

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 84% said the last GP they saw was good at involving them in decisions about their care (CCG average 82% , national average 81%)

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. Written information about local services was available for carers on reception to ensure they understood the various avenues of support available to them. The

Good

Are services caring?

deputy practice manager was aware of the date of National Carers' Week and told us the practice always received additional information around this time to promote support services to carers.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. One of the GPs attended the CCG council of members and another sat on the local medical committee. The practice manager attended the practice managers' forum. One of the GPs was to attend a forthcoming practice summit facilitated by the CCG to look at the future of GP Practice in Norwich over the next few years.

The practice offered a wide range of services to patients in addition to chronic disease management. This included phlebotomy, condom supply, chlamydia screening, diabetic retinal screening, on site hearing aid batteries, physiotherapy, minor surgery and travel advice. It also offered an influenza vaccination service and had recently provided flu clinics on three separate Saturdays in order to meet patients' needs.

The practice was able to meet the needs of patients with disabilities. There were disabled car spaces available in its car park and wheelchair access through its main entrance. A ramp was available to access the annex building. The practice's reception desk was lowered at one end to enable better communication with wheelchair users. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The waiting area was large with plenty of space for wheelchairs and prams. A hearing induction loop was also available.

Translation services were available if needed and the practice self-check in service was available in a number of languages.

Home visits were available for older patients or patients who would benefit from these and same day appointments were available for children and those with serious medical conditions. The practice offered a weekly 'ward round' to four local care homes, providing regular contact and continuity of care for residents living there.

All the practice's partners were male, however we were assured that there were usually female registrars working at the practice, and also two female nurse practitioners to see patients who preferred a female clinician. Information about this was available to patients on the practice's web site and also

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

Access to the service

Information was available to patients about appointments on the practice's website and in its patient information leaflet and appointments could be booked in person, by telephone or on-line.

The practice was open between 8.30 am and 6.30 pm Monday to Friday, with appointments available between 8.30am and 12 noon, and again between 2pm and 6pm.The practice did not offer extended hours opening.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages, despite it not offering extended hours.

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and national average of 75%.
- 92% patients said they could get through easily to the surgery by phone (CCG average 73%, national average 73%).
- 86% patients described their experience of making an appointment as good (CCG average 74%, national average 74%.
- 71% patients said they usually waited 15 minutes or less after their appointment time (CCG average 65%, national average 65%).

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns and its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We saw that information was available to help patients understand the complaints system on the practice's website and in its

Good

Are services responsive to people's needs?

(for example, to feedback?)

information booklet. Reception staff showed a good knowledge of the practice's complaints procedure and spoke knowledgably about the various ways patients could raise their concerns.

All full analysis of all complaints received by the practice was undertaken every year to identify any common themes and we viewed minutes of these meetings that went back a number of years. Each complaint was triaged in relation to its type such clinical care, attitude and manner of staff or administrative processes, and actions resulting from the analyses had been clearly document. Although only the partners attended these meetings, staff told us that any complaints relation to their area of work were regularly shared with them.

We viewed documentation in relation to five recent complaints and found they had been fully investigated and responded to in a timely and empathetic way.

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

Although staff we spoke with were not aware of the practice's specific vision and strategy, they were clearly committed to providing a high quality service to the patients that they served.

We found that practice staff were well aware of future challenges they faced including a new housing development and the need for robust succession planning with the possible retirement of one partner. The partners had held specific business planning outside of surgery hours to discuss and address these challenges.

Governance arrangements

The practice had a number of policies and procedures in place to govern its activity and these were available to staff on the practice's computer systems. Staff had signed the policies to indicate that they had read, understood and agreed to abide by them. We looked at 10 policies and procedures and found that they were up to date and had been reviewed regularly.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and partners took lead roles for safeguarding, training and chronic disease. Staff we spoke with were all clear about their own roles and responsibilities.

The practice manager told us he had put together a 'Managers Continuity Kit' with information and protocols about all aspects of his role should he suddenly become unavailable.

Communication across the practice was structured around key scheduled meetings. There were weekly practice meetings involving the GPs and the practice manager, regular nurses' meetings and staff meetings involving all administrative staff. Although there were no practice wide meetings involving all the staff, staff attended the partners' meetings when it was relevant and appropriate for them to do so.

We found that the quality of record keeping within the practice was generally very good, with minutes and records required by regulation for the safety of patients being detailed, maintained, up to date and accurate.

Leadership, openness and transparency

We found that the partners and practice manager had the experience, capacity and capability to run the practice and ensure high quality care.

The nurse and registrars we spoke with both told us they felt well supported by staff and that GPs were easily available if they needed to seek advice or discuss clinical matters. A member of the patient participation group reported that the practice manager was very open about the challenges the practice faced.

Staff told us that regular team meetings were held, where they felt able to raise their concerns. They reported that their ideas were listened to by the partners. For example, the deputy practice manager told us that reception staff's suggestion to hold flu clinics on a Saturday had been implemented, with considerable success.

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

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had recently conducted a wide ranging survey which asked staff for feedback, amongst other things, about their working relationships, their ability to make decisions and the efficiency and number of team meetings. Results were available on the staff noticeboard for all to see. The survey had identified the need for better communication between staff and the different departments within the practice. As a result the practice manager had implemented the 'Manager's Mouthpiece'- a weekly newsletter to keep staff up to date with events and news.

The practice gathered feedback from patients through the patient participation group and through surveys and complaints received. A suggestion box in reception area was available for patients to leave comments in. There was an active patient participation group (PPG) which met four times a year. We spoke with one member of the group who reported that the practice manager was good at keeping the group up to date with what was happening within the practice. He reported that the PPG's suggestions to improve the service were listened to and acted upon by the practice. For example, an electronic notice board for the waiting area which could be used to identify staff had been

Are services well-led?

Good

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

installed; seating with arm support for patients with mobility difficulties had been purchased, and hand sanitiser next to the touch screen booking in system had been provided so that patients could cleanse their hands.

The practice had been actively monitoring comments it had received on the NHS Choices website and where patients had raised concerns, we saw that these had been replied to with patients invited to contact the practice to discuss their concerns.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Results from August 2015 showed that 92% of patients would be likely to recommend the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13- Safeguarding service users from abuse and improper treatment. Not all staff who undertook chaperone duties had received training for this role, or had been risk assessed regarding the need for a DBS check. Regulation 13 (2) .