Long Stratton Medical Partnership

Quality Report

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Date of inspection visit: 10 November 2014
Date of publication: 19/02/2015

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Long Stratton Medical Partnership on the 10 November 2014 and carried out a comprehensive inspection.

The overall rating for this practice is good. We found that the practice provided a safe, effective, caring, responsive and well led service. We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

Our key findings were as follows:

- Patients felt they were treated with dignity, care and respect by all staff. They were involved in decisions about their care and treatment and were happy with the care that they received from the practice.
- The practice was a friendly, caring and responsive practice that addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- Patients commented positively on the dispensary providing a quick and efficient service.
- Patients at the practice had a named GP and we saw evidence of continuity of care.
- Patients were satisfied with the appointment system at Long Stratton, although some patients told us that it was more difficult to see their named GP at the branch surgery.
- The needs of the practice population were understood and the practice was proactive in developing services to ensure the needs of patients were met effectively.
- The practice clinical leadership was effective and there was a strong emphasis on learning and development to improve the service provided to patients.

We saw several areas of outstanding practice including:

Summary of findings

- People who cared for others were identified and were proactively supported by a carer's coordinator who was employed by the practice.
- The practice had established a free medicine delivery service for vulnerable patients in the community. This also ensured that vulnerable patients also received a regular welfare check and concerns were reported back to the GP.
- The practice held regular multiple-condition clinics where patients with three or more long term conditions were reviewed by a multi-disciplinary team, so there was a consensus decision on the most optimum care and treatment.
- The GP always made a home visit to families who had experienced unexpected bereavement.
- The partners had completed an analysis of their behavioural strengths and weaknesses and used this in order to maximise the effectiveness of their leadership team.

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

The provider should:

- Ensure that there are cleaning schedules in place and that the checks of the cleaning are undertaken on a regular basis.
- Ensure that the actions identified in the fire risk assessment are completed.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and 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 an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). 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. Patients aged 75 and over had a named accountable GP who was responsible for their care and treatment. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice had developed their own proposal for the admission avoidance plan for people who were aged 75 and over. This had been undertaken in liaison with other GP colleagues and had been approved by the clinical commission group (CCG). The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs. There was evidence of effective multidisciplinary working to optimise their health care and also reduced unplanned admissions to hospital.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals were made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. Some of the nurses in the practice specialised in this area and there was a robust system in place for reviewing patients. This included the review of patient with long term conditions who lived in a care home. All patients had a named GP and structured reviews, at least annually to check their health and medication needs were being met. For those patients with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients with multiple long term conditions were reviewed in a multiple condition clinic, in order to provide optimum care and treatment.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Information and advice was available to promote health to women before, during and after pregnancy. Expectant mothers had access to midwife clinics which occurred twice a week. The GPs undertook six week baby checks in conjunction with a post natal check for the mother. Immunisation rates were relatively high for all standard childhood immunisations.

Summary of findings

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. The practice offered online services and telephone access to a GP. A full range of health promotion and screening services which reflected the needs for this age group were available.

People whose circumstances may make them vulnerable

Good

The practice provided a good service to people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, family carers and those with learning disabilities. The practice was well established within the community and knew their patient group well.

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

People experiencing poor mental health (including people with dementia)

Good

The service was safe, effective, caring and responsive for people experiencing poor mental health. Patients were able to access services either through an open access appointment or booking in advance. The practice liaised with the patient and offered regular health care reviews of their condition, treatment and medication. Extended appointments were available to patients in this group. The practice held clinical meetings to review the care received by patients and liaised with local community mental health teams. We

saw that physical health checks had been made available to people with a mental health need and that these were proactively followed up if a patient did not attend the practice. We noted that the practice had challenged local decision making around the provision of mental health services in both acute and therapeutic settings. They had fed back issues to the local clinical commissioning group where they had identified gaps in access to counselling and treatment for this population group.

Summary of findings

What people who use the service say

We spoke with 18 patients during our inspection. All the patients told us that they were able to get an appointment easily with their named GP at Long Stratton, although this was more difficult at the branch surgery. They confirmed that they were able to obtain an urgent, on the day appointment if this was necessary. All of the patients we spoke with informed us they were involved in decisions about their care and treatment and were treated with dignity and respect by staff at the practice. A number of patients commented positively on the practice being clean and tidy.

We collected 37 Care Quality Commission comment cards from a box left in the practice approximately two weeks before our inspection. All of the comments on the cards gave positive feedback about the practice and five included some less positive feedback, primarily about the time they had to wait to get an appointment.

We spoke with representatives from two care homes where patients were registered with the practice. We received positive comments regarding the clinical care provided by the practice, particularly in relation to the continuity of the GP.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that there are cleaning schedules in place and that the checks of the cleaning are undertaken on a regular basis.
- Ensure that the actions identified in the fire risk assessment are completed.

Outstanding practice

- People who cared for others were identified and their needs were also proactively managed by a carer's coordinator who was employed by the practice.
- The practice had established a free medicine delivery service for vulnerable patients in the community. This also ensured that vulnerable patients also received a regular welfare check and concerns were reported back to the GP.
- The practice held regular multiple-condition clinics where patients with three or more long term conditions were reviewed by a multi-disciplinary team, so there was a consensus decision on the most optimum care and treatment.
- The GP always made a home visit to families who had experienced unexpected bereavement.
- The partners had completed an analysis of their behavioural strengths and weaknesses and used this in order to maximise the effectiveness of their leadership team.

Long Stratton Medical Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team also included a practice management specialist advisor, a second CQC inspector and an expert by experience.

Background to Long Stratton Medical Partnership

Long Stratton Medical Partnership is in the South Norfolk clinical commissioning group (CCG) area and provides general medical services. The practice has approximately 11,220 registered patients. They have a branch surgery at Newton Flotman, St Mary's Close, Newton Flotman. This was not visited as part of our inspection.

According to Public Health England information, Long Stratton Medical Partnership has a slightly higher proportion of patients aged over 65, compared to the practice average across England. Income deprivation affecting children and older people is lower than the practice average across England.

The practice is a partnership of seven GPs who hold financial and managerial responsibility for the practice. The practice employs six registered nurses, two health care assistants and a dispensary team, which includes a manager and senior dispenser. There is a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles.

The practice is a dispensing practice and patients obtain their medicines either from the Long Stratton surgery, or from the Newton Flotman surgery. A dispensing practice is where GPs are allowed to dispense the medicines they prescribe for patients who live too far away from a community pharmacy.

The practice is a training practice for GP Registrars, who are qualified doctors, training to be GPs. The surgery also works in collaboration with the University of East Anglia to help train medical students.

In 2012 the Royal College of General Practitioners awarded the practice a Quality Practice Award, in recognition of their proven commitment and the achievements demonstrated over an assessment lasting almost two years.

Long Stratton Medical Partnership does not provide an out-of-hours service to patients. The out-of-hours services is provided by East of England Ambulance Service NHS Trust. Details of how to access emergency and non-emergency treatment and advice is available within the practice and on their website.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 10 November 2014. During our visit we spoke with a range of staff, including five GPs, three practice nurses, a health care assistant, dispensary staff, reception and administration staff and the practice manager.

We spoke with three members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We also spoke with 18 patients who used the practice. We reviewed 37 CQC comments cards that we had left for patients to complete if they chose. We observed how staff interacted with patients and reviewed the treatment records of patients.

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

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

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

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

Good

Are services safe?

Our findings

Safe Track Record

We found that there were systems in place for reporting issues and concerns which may pose a risk to patients and staff. There was a robust system for reporting significant events and regular audits were led by clinicians to explore the effectiveness of care and whether changes in processes were necessary.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). These alerts contain safety and risk information regarding medication and equipment. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. The partners held an annual meeting to review the practice's safety record over the previous year and to check that the actions taken had been effective. We saw the minutes of this meeting which confirmed the practice had a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff recorded incidents when they occurred. The practice manager formally recorded the incidents ready for investigations to be carried out.

All staff we spoke with confirmed that there was a culture at the practice which encouraged and supported the investigation of concerns and the robust reporting of incidents and near misses. We saw examples of this happening in practice across clinical, administrative and dispensing areas. A data recording issue had been flagged as a serious incident and was being investigated by the IT Lead. We saw an example of a prescription that had been dispensed in error had been investigated and new processes adopted to prevent re-occurrence. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The practice staff had notified the Clinical Commissioning Group (CCG) of individual events. The CCG are responsible for commissioning and monitoring the standards of the services provided by GP practices.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated GP lead for safeguarding vulnerable adults and children. This lead GP had oversight for safeguarding and acted as a resource for the practice. Staff we spoke with were aware of who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's patient record system. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example, cared for children or those children who were subject to child protection plans, elderly patients and patients who had a learning disability. Records showed that vulnerable adults and children were discussed at clinical meetings and there was evidence of an effective working relationship with the health visitor and school nurse.

Patient's individual records were written and managed in a way to ensure safety. Records that were kept on the computerised patient record system had collated all communications about patients, including electronic scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings that were identified.

A chaperone policy was in place and was visible on the waiting room noticeboard and in consulting rooms. The chaperone service was provided only by clinical staff who had received appropriate training. Patients we spoke with were aware that they could have a chaperone during their consultation, if they wished to do so.

Medicines Management

The dispensary was managed by a dispensary manager and lead by an accountable GP. There were clear standard

operating procedures explaining how to manage issues such as medication errors, waste management and dispensing processes. These had been updated appropriately.

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been seen and signed by a GP. Patients told us they were satisfied with the repeat prescription processes. Patients had been notified of health checks that were necessary before medicines were prescribed. Patients explained they could use a request box in the practice, telephone, or use the on-line request facility for repeat prescriptions. Patients explained they could collect their medicines from a place of their choice. There were clear systems to ensure these requests were followed.

Medication in the dispensary was stored safely. Medication was supplied to the dispensary in secured delivery boxes and records kept of these stock checks. The dispensary was alarmed, secure and was not accessible to members of the general public. The dispensary areas were clean and free from a build-up of excess stock. Hand washing facilities, aprons and gloves were available for staff to use.

The dispensing staff had received training in medication management and dispensing to a minimum of NVQ level 2. Staff had access to detailed standard operating procedures for guidance which had been recently reviewed.

We checked the controlled drugs storage and management and found these to be appropriate. Controlled drugs are types of medicines which required additional storage and record keeping. There was a clear audit trail of receipt and issue of controlled drugs. The practice had clear procedures in place for the disposal of controlled drugs.

There were systems in place for the obtaining, using, storing and supply of medicines in the dispensary. However there was scope to improve the safe storage of medicines held in the minor surgery room. The medicines cupboards and emergency drugs trolley were easily accessible to anyone accessing the nursing corridor. There was also scope to provide notices on the doors of rooms which contained medical gases. After our inspection we were informed by the practice manager that medicines that had been kept in the minor surgery room were removed and only stored in the dispensary. We were informed that the minor surgery room was going to have a key pad fitted to reduce the risk of unauthorised access.

All of the medicines we saw were in date. Deliveries of refrigerated medicines were immediately checked and placed in the refrigerator which ensured that storage at the appropriate temperature was maintained. We looked at the storage facilities for refrigerated medicines and immunisations. Fridge temperatures were monitored daily to ensure that medicines remained effective. Where refrigeration temperatures occasionally exceeded the maximum acceptable for safe storage, this had been recorded. However, the actions taken in response to the high readings had not always been documented. We discussed this with the practice manager, who told us that they had instructed staff to ensure that the actions taken would be documented immediately. Dispensary staff told us that when there had been an issue with one of the refrigerators, a replacement had been obtained immediately.

Patients were informed of the reason for any medication prescribed and the dosage. Where appropriate patients were warned of any side effects, for example, the likelihood of drowsiness. All patients said they were provided with information leaflets supplied with the medication to check for side effects.

The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to patient's medicines were authorised by the prescriber.

We discussed medication errors with dispensary staff who demonstrated their knowledge around the importance of reporting any issues immediately. We reviewed one incident where a patient had been issued the wrong medication and saw evidence of how the error was reported and corrected and that learning was embedded across the dispensary team to prevent re-occurrence.

Cleanliness & Infection Control

Overall we observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with liquid hand soap, hand gel and hand

towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice employed an external cleaning company for the general cleaning of the premises. There were no cleaning schedules in place and there was no system in place for the practice to undertake checks of the cleaning. During our inspection we found that the minor surgery room was not clean and there was high level dust on the curtain rails. We also noted that fabric curtains were used in the minor surgery room and there was no evidence that these were regularly cleaned. Following our inspection the practice manager advised that a deep clean of the minor surgery room had been undertaken. They had sourced another cleaning contractor and cleaning schedules and regular audits of the cleaning would be in place. The practice had ordered disposable curtains for use in all the treatment and consultation rooms and was waiting for these to be delivered.

The practice had a lead for infection control who had undertaken further training to enable them to undertake this role effectively. We were told and records confirmed that other staff completed e-learning on infection control. They were also able to speak with the lead nurse if they had any questions or concerns in this area. We saw that audits were carried out annually to test the effectiveness of the infection control procedures within the practice and to identify any areas where improvements were needed. The results of the last audit, dated 1 April 2014 was seen and where areas for improvements had been identified there were action plans in place to ensure that these improvements were made.

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. During our inspection we noted that sharps bins were not always labelled appropriately or locked when they had been used. We raised this with the practice manager who has confirmed that these are now labelled and locked in line with guidance. Medical equipment including blood pressure monitoring devices, scales, thermometers and emergency equipment such as an automatic external defibrillator were periodically checked and calibrated to ensure accurate results for patients. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. All equipment was regularly checked and records were kept to show when these checks were carried out. Where appropriate, equipment was serviced in line with the manufacturer's recommendations.

Staffing & Recruitment

Staff told us there were always enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. The practice manager showed us records to demonstrate that staffing levels and skill mix were in line with planned staffing requirements. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that extra staff were employed, if required, to deal with any changes in demand to the service as a result of both unforeseen and expected situations, such as seasonal variations (winter pressures) or adverse weather conditions.

There was no formal recruitment policy at the practice, however the practice manager explained the process they had used when recruiting staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to people being employed. In the staff records we reviewed we saw proof of identification, references, qualifications, registration with the appropriate clinical professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice manager told us that they would ensure that the standards agreed for the safe recruitment of staff were formally documented. We received a copy of the recruitment policy following the inspection.

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Good

Are services safe?

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff (apart from two non-clinical staff) had received training in basic life support. Emergency medicines and equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a current business continuity plan, which identified what the main possible risks were to the practice and how there could be dealt with. A plan of action was in place for each of the high and medium risks and for the majority of the low risks. For example, clerical and management routine procedures were documented so that other staff could undertake these roles if needed. Most of the staff we spoke with were aware of the business continuity plan. We were advised that a copy was kept with managerial staff and a copy was kept off site.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. The practice was addressing the actions from the fire risk assessment. We saw that fire equipment was available and the extinguishers had been checked in 2014. There was a fire plan on display in the entrance area and fire notices and equipment were available throughout the building. We saw records that showed approximately two thirds of staff had undertaken fire training. The staff we spoke with were aware of their role and responsibility in relation to fire safety and in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. We saw that practice management meetings included discussions on expected standards of care. New information or guidance from the Clinical Commissioning Group (CCG) prescribing committee or quality standards from the National Institute for Health and Care Excellence (NICE) were considered during these discussions. As a result, the practice's management plans and protocols for particular conditions or treatments were updated and put into practice.

Clinical staff told us that they led in specialist clinical areas such as mental health, sexual health and diabetes. Staff were very open about asking for and providing colleagues with clinical advice and support. The practice had a number of well-established clinics for conditions such as asthma and diabetes and for baby immunisations. A diabetes facilitator regularly visited the practice to meet with the nurse lead for diabetes to review patients with complex diabetes. These ensured that services were provided to effectively meet the needs of the patients.

The practice used their computer records system through the quality and outcomes framework (QOF) to identify and monitor particular patients within certain groups and to tailor any interventions according to their need. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. The practice had identified that they had a low prevalence of chronic kidney disease. They undertook a search to identify potential patients with this disease. These patients were then reviewed and further tests arranged. There had been an improvement in the number of patients correctly diagnosed and offered appropriate support and treatment.

During our interviews with GPs and staff and throughout our observations we saw no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

The practice participated in clinical audits and peer review, which led to improvements in clinical care. Clinical audits and peer review are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved.

We looked at two completed clinical audit cycles. The first related to patients prescribed a specific medication and their need to be reviewed to assess whether an additional gastrointestinal medication should also be prescribed as a protective factor. We saw evidence of an increase in patients prescribed the protective medicine, which resulted in positive outcomes for patients. Another clinical audit concerned the low prevalence of hypertension. Patients who may have raised blood pressure were identified from a review of their medical record and were then reviewed during two 'hypertension' days held at the practice. Appropriate testing and treatment was arranged. Repeat audit cycles have shown an increase in prevalence of hypertension and these patients receiving appropriate care and treatment.

Doctors in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and National Institute for Health and Care Excellence (NICE) guidance. The staff were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and applied that in their learning.

The practice held a multi-condition clinic for patients with multiple long term conditions and where their care was complex. This involved a multi-disciplinary meeting to review the patient's needs. If appropriate, tests were requested and when the results had been received, the patient was reviewed by the GP in the multi condition clinic. A meeting between the GP and the nurse was held in the morning of the clinic, to update their knowledge of the patients' results and care and treatment suggested by the multidisciplinary team.

The practice was participating in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for patients most at risk of unplanned admissions and regular review meetings were held to assess effectiveness. Patients who were at the end of their life we also reviewed regularly by a multi-disciplinary team. We found that the practice had

Good

Are services effective?

(for example, treatment is effective)

been effective in reducing the number of admissions. There was also evidence that patients' needs had been anticipated proactively so that appropriate support was available when this was needed.

Effective staffing

All staff, apart from one, had received an annual appraisal. These had been used to identify staff learning needs, from which action plans were agreed. We noted that the appraisal date had been scheduled for the member of staff who was due an appraisal. We saw that staff had been supported by the practice to develop their skills and knowledge. For example, one of the nurses told us that they were undertaking a diabetes course and had previously completed a sexual health course, which was funded by the practice. Another member of staff was being supported to complete a National Vocational Qualification (NVQ) in business administration.

We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with the NHS England).

As the practice was a training practice, doctors who were in training to be qualified as GPs offered extended appointments to patients and had access to a GP partner throughout the day for clinical support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. This included the administration of vaccines and cervical cytology. Those with extended roles which included seeing patients with long term conditions, such as diabetes and asthma were also able to demonstrate they had appropriate training to fulfil these roles.

We found that staff were given support and guidance to ensure they were able to undertake their role safely and effectively. There was an effective induction programme in place which covered staff responsibilities in areas such as health and safety, fire safety, confidentiality and emergency situations. The induction also included specific job training which was provided by the department lead. New staff we spoke with confirmed they had received an induction. We saw that a three month appraisals had been undertaken when staff had completed their induction to ensure they had achieved the required competency.

Working with colleagues and other services

The practice worked with other service providers to support people with complex needs. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The named GP was responsible for reviewing these documents and results and for the action required. There was a buddy system in place to cover GP annual leave or sickness. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

We found that the practice engaged regularly with a range of health and social care providers in the area. The practice worked with a multidisciplinary team to review patients for the multi-condition clinic. They also held palliative care team meetings on a monthly basis to discuss the needs of those patients at the end of their life. These meetings were attended by the GPs, palliative care nurses and community nurses. Decisions about care planning were documented in a shared care record.

There was a nurse lead for sexual health, who had good links with the school nurse. We saw evidence that the clinical staff had good working relationships with the health visitors.

Up to date information and contact details for local health and care services, such as mental health services and support groups was available in the waiting room. To support this, the practice website also had a dedicated page linked to NHS Choices to help patients find local health care services such as hospitals, dentists, chemists and independent healthcare providers

Good

Are services effective?

(for example, treatment is effective)

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record (EMIS Web) was used by all staff to coordinate, document and manage patients' care. The system enabled alerts to be communicated about particular patients such as information about children known to be at risk. For example, for patients who were caring for others, the caring responsibility was marked on the summary record of a patient when they attended the practice as a patient in their own right so that the social and psychological factors associated with caring for others could be addressed in care planning. All staff were fully trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Patients were able to have access to their medical records and were asked for their consent to share their medical records with other services. We saw that information was shared appropriately between the other services involved in patient's care. Records we saw showed that palliative care meetings took place monthly with a range of professionals to ensure there was a joined up approach to care and treatment for the patient. There was effective information sharing for example with the out of hours provider and district nurses. We saw that information regarding patients who were at the end of life was shared with the out of hours provider. This ensured that care and support would be seamless if the patient needed a GP out of hours.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary. We were shown two examples of completed written consent forms for minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients that we spoke with and received comments from confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an in depth understanding of the legal requirements when treating children. The practice nurse confirmed written consent was always obtained from parents prior to immunisations being given. We were shown a consent form which listed the schedule of childhood immunisations from birth to 14 years of age, which could be consented to in advance.

Staff also understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Guidance was available to staff in relation to The Mental Capacity Act (MCA) (2005). This provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. One of the GPs we spoke with had undertaken an online learning module on the Mental Capacity Act (2005) and we saw their certificate for this. The GPs we spoke with were aware of the requirements of the Mental Capacity Act (2005) and their responsibilities in relation to this. All staff were aware of patients who needed support from nominated carers and clinicians ensured that carers' views were listened to as appropriate.

Health Promotion & Prevention

We saw that there was a large range of health promotion information leaflets and posters in the waiting areas. The practice website also had information pages which related to family health, long term conditions and minor illness.

We saw that new patients were invited into the practice when they registered to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and health screening. The new patient health check was undertaken by a health care assistant. However, if the patient was prescribed medicines or if there were any health risks identified then their new patient check was undertaken by their GP. We were told by the clinical staff that patients were signposted to other services and there was an emphasis on self-management where possible.

The practice kept a register of patients with learning disabilities. We saw that 59 patients were recorded on the register. The reception team took the lead in co-ordinating and arranging annual health checks. They told us that they contacted patients or their carer to book appointments for annual health checks. From records we saw that 59% of these patients had already attended their appointments for an annual health check in 2014. The practice had health

Good

Are services effective?

(for example, treatment is effective)

check appointments in place for the remainder of this group of patients. Staff told us that patients were proactively encouraged to attend appointments and that attendance levels were therefore good.

Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Through discussion with staff and from records viewed we saw that the practice performed well and had a high uptake for both childhood immunisations.

We looked at the Quality and Outcomes framework (QOF) data, which is an annual incentive programme designed to reward good practice. The practice scored positively across the majority of the public health indicators. They scored significantly above the CCG and England average for cardiovascular disease primary prevention.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

There was a strong, visible person centred culture and staff and management were fully committed to working in partnership with patients. All of the patients we spoke with and received comments from, during our inspection made positive comments about the practice and the service they provided. They were complimentary about the caring, friendly and helpful attitude of both the clinical and non-clinical staff. Patients also told us that they were listened to and were treated with dignity and respect by all the staff.

During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. We saw that patient's confidentiality was respected when care was being delivered and during discussions that staff were having with patients. Facilities were available for patients to talk confidentially to clinical and non-clinical staff members. However we did note that during our inspection patients checking in at the reception desk could be overheard, especially when the waiting was less busy, as there was no background noise.

We looked at data from the 2014 National GP Patient Survey. We noted that 90% of patients stated they would recommend the practice. 93% of patients reported that the reception staff were helpful with 77% reporting that they were satisfied with the level of privacy in reception. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (90%) and by their doctor (86%). These results were above average when compared with other practices in the Clinical Commissioning Group (CCG) area.

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The clinical staff we spoke with told us that they provided information to support patients to make decisions about their care and treatment. This included giving patients the time they needed to ensure they understood the care and treatment they required. The patients we spoke with and the comments cards we received, confirmed this. Patients told us they received thorough explanations about their care and treatment, were listened to, and were involved in decisions.

We found that patients were involved in decisions about their treatment. The 2014 National GP Patient Survey showed that 91% of patients felt the GP was good giving them enough time, 89% felt that the GP was good at listening to them and 88% felt that the GP was good at explaining test results to them. 76% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were higher than the average for the local Clinical Commissioning Group (CCG) area. The corresponding figures for the nursing staff were also rated higher than the CCG average. 93% of patients felt the nurse was good at giving them enough time, 91% felt that the nurse was good at listening to them, 89% felt that the nurse was good at explaining test results to them and 75% of patients felt that the nurse was good at involving them in decisions about their care.

The practice had access to INTRAN translation services funded by the South Norfolk Clinical Commissioning Group. This service was predominantly a telephone based service; however translators could be requested to attend the practice if required. The service offered British Sign Language interpreters, lip speakers and interpreters in 150 languages.

Patient/carer support to cope emotionally with care and treatment

The practice was proactive at identifying patients who had a carer, and patients who were carers, and had offered them support. The practice used opportunities such as the influenza clinic to identify patients who had recently taken on a caring role. The practice employed a carers coordinator who had identified 139 people with caring responsibilities and this was recorded on these patients' records. Patients were asked to complete a consent form to agree to this information being recorded in their medical record.

Patients who had a carer or were a carer, were referred to the carer's coordinator who arranged to meet with them. The carer's coordinator provided them with a carer's handbook, sign posted to local support groups and acted as an on-going source of support and advice. A carer's information resource folder was available in the waiting room. The practice also offered influenza vaccinations to all patients who were identified as carers.

Good

Are services caring?

One patient we spoke with told us that their GP had been very supportive when they had started to take care of their family member. The GP had supported them to seek additional financial support and to attend a social group for carers.

Staff told us families who had suffered bereavement were identified and the electronic records system was updated to inform all staff at the practice. They told us that recently bereaved families were called by their usual GP. This call was either followed by a consultation at the practice, or a home visit where this was more appropriate. For unexpected bereavement, the GP always made a home visit. Cards were also sent to some bereaved families. GPs referred patients to CRUSE (a national charity for bereaved people in England) or gave information on self-referral to the wellbeing service. There was a variety of written information available to advise bereaved relatives and direct them to the local and nationally available support and help organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. Arrangements were in place to support patients with a range of needs. The practice system alerted staff to patients with impaired hearing or sight, prompting staff to offer additional support during their time in the practice. Where patients did not speak English as a first language, interpreting services were made available to support them to fully access the service. Staff confirmed that where patients were unable to read or write, the reception team would provide support to complete necessary paperwork. Where patients required longer appointments due to increased communication needs or vulnerability, these were made available. One care home manager we spoke with commented on how well the practice responded to the needs of patients who were anxious. They explained that patients were frequently seen immediately by their GP, on arrival at the practice.

The practice had taken on board feedback from their Patient Reference Group (PRG) around providing a more accessible pharmacy service. The PRG is a forum made up of patient representatives and staff who discuss changes within the practice and how services can be improved for patients. As a result the practice had recently introduced a free delivery service, taking medicines to the homes of patients who were housebound or living in rural isolation. This also ensured that those patients received a regular welfare check and any concerns were reported back to the patients GP.

We were told by the partners how they had placed a bid for an initiative to reduce avoidable hospital admissions for patients aged 75 and over. The CCG had accepted this bid because it sought to deliver improved outcomes for this population group.

Tackling inequity and promoting equality

Arrangements were in place to support patients with specific communication needs. The practice system alerted staff where patients were hard of hearing or had issues with their sight, prompting staff to offer additional support during their time in the practice. Where patients did not speak English as a first language, interpreting services were made available to support them to fully access the service. Staff confirmed that where patients were unable to read or write, the reception team would provide support to fill our necessary paperwork. Where patients required longer appointments due to increased communication needs, these were made available.

The practice had identified that there were no therapeutic mental health services for patients who were 18 to 25 years old. They had raised this with the Clinical Commissioning Group (CCG) and were advocating that these services needed to be provided. The practice did refer patients to an improving access to psychological therapy service. They also provided a recommended reading list on cognitive behavioural therapy to patients as a form of self-help.

Access to the service

Details of the appointment system, which included how the personal list operated, routine appointments, telephone appointments, same day appointments and waiting times were available in the practice patient information leaflet and on the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. Patients could access, change or cancel booked appointments via the practice website or the telephone booking system

The surgery at Long Stratton was open Monday to Friday from 8.15am to 6pm. The branch surgery at Newton Flotman was open on Mondays, Tuesdays and Thursdays from 8:15am to 6pm. We received positive comments about the appointment system at Long Stratton. However we received some negative comments about difficulties with accessing appointments at the branch surgery. The partners were aware of this issue and felt that access to GPs and appointments was acceptable and did not warrant any change in the system. We saw in minutes of meetings that this situation was regularly reviewed.

The practice operated a personal list, so every patient had a named GP. Consideration was given to the patients' circumstances and preferences where possible when allocating patients to a named GP. There was a process in place where patients could request to change GP and we saw examples of when this had occurred. Patients were offered the next available appointment with their GP when they requested a routine appointment. Same day appointments were booked in call order and were not always with the patients named GP. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the

Good

Are services responsive to people's needs?

(for example, to feedback?)

same day of contacting the practice. Home visits were undertaken by the named GP. All requests for a home visit were responded to by telephone by the named GP to make a clinical decision on the need for a home visit.

The practice was situated on the ground and first floors of the building. Services for patients were available on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Patients were called by the clinician they were seeing from the waiting room, so if a patient needed assistance this could be provided. There was an accessible toilet which had an emergency pull cord.

Listening and learning from concerns & complaints

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

We saw that information was available to help patients understand the complaints system. There was information on making a complaint in the practice patient information leaflet, on the practice website and on the complaints form available at reception. Patients we spoke with were aware of the process to follow should they wish to make a complaint. One of the patients we spoke with advised they had made a complaint and expressed satisfaction with both how it was handled by the practice, and the outcome. Other patients we spoke with had not needed to make a complaint but they believed that any complaint would be taken seriously.

We looked at three complaints received in the last twelve months. These had been acknowledged, investigated and a response had been sent to the complainant. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate. There was evidence that complaints were discussed at the weekly and monthly partners meeting, as appropriate.

The practice reviewed complaints on an annual basis. We looked at the review of complaints from November 2013 to October 2014. Themes and trends had been identified and learning had been acted upon.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. A senior partner told us that the ethos of the practice was to provide an 'old fashioned personalised service using the best evidence.' Although this was not documented, it was evident during our inspection. Our conversations with staff and patients demonstrated that this approach was effective as everyone we spoke with was able to articulate the values of the practice, namely 'doing our best for the patient'. All staff that we spoke with knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these. They told us they were encouraged to make suggestions that led to improved patient care. All the staff we spoke with said they felt supported and listened to by the partners and practice manager. We received very positive feedback and comments from the patients.

We saw the minutes of an away day held in 2013 where the partners had discussed their strategy for the next year. This included discussion around succession planning. As part of the development of the partnership team work had already been undertaken and included an analysis of the strengths and weaknesses of each of the partners team roles, using 'Belbin's team roles' as a model. This is a framework for identifying the behavioural strengths and weaknesses of the individuals within the team in order to help build high-performing teams and maximise working relationships.

Governance Arrangements

We found that there were effective governance arrangements in place and that staff were aware of their own roles and responsibilities. For example, we saw that some staff members had designated lead roles for different aspects of the practice's business, such as the designated lead nurses for diabetes and infection control. All of the GPs had lead roles for different clinical aspects according to their own areas of interest. We saw that the practice also had a designated 'Caldicott Guardian', the person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.

As well as having robust strategic governance in place, the practice also had clear systems and processes that enabled it to operate effectively. We saw, for instance, that key policies were monitored by a member of the management team and were delegated to key members of staff with particular expertise when they were due for review. This ensured that policies and protocols were relevant and reflected current guidance.

There was also a system for managing variable performance of staff that was robust as well as being fair and proportionate. We found evidence of this process being applied effectively.

Leadership, openness and transparency

The practice had successfully created a culture where staff were empowered to admit error and to learn from it. Regular practice meetings were held and the review of the register of all accidents/incidents and significant events was a standing agenda item. Lessons learned from clinical and non-clinical incidents were discussed and disseminated to all relevant staff. We spoke with dispensing staff, administrative staff, reception staff, nurses and GPs and they all described a working environment where issues and concerns could be openly discussed and investigated without blame. Dispensary, clinical and administrative staff told us that they were proactively encouraged to engage in a cycle of continuous learning and that the practice was honest and aware about what it could do better. The practice participated in external peer review, for example the prescribing lead attended the local commissioning group prescribing meetings.

The practice partners engaged well with one another in a non-hierarchical system which succeeded in exploiting the strengths of each staff member. Partners exhibited self-awareness and openness and had identified areas where the practice could improve. The practice also engaged actively with external stakeholders, seeking opportunities to challenge and shape the local health economy. They demonstrated this by vocalising the need for improved local provision of mental health services. The practice had also placed a bid to provide a better service for its patient population aged 75 and above. The CCG had accepted the bid because it sought to deliver a more secure long term service to this population group.

The partners meet on a regular weekly and monthly basis to discuss issues relating to the practice. This included discussions regarding clinical care, staffing issues, patient requests to change their name GP and quality reporting. There was also an informal weekly meeting where the lead in each department discussed and issues within their

Are services well-led?

Good

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

department and whether they had any issues which needed to be addressed. This information was fed into the weekly partners meeting. There was also evidence of department team meetings and the staff we spoke with told us they found these useful and felt supported by the practice.

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

The practice had a patient reference group (PRG) and a patient participation group (PPG). The PRG was made up of practice staff and patients that were representative of the practice population. The main aim of the PRG and the PPG was to ensure that patients were involved with decisions about the quality of the services provided by practice staff. We spoke with three members of the group and they told us they were planning to hold face to face meetings to strengthen the effectiveness of the PRG. Staff told us that feedback from the PPG had led to the establishment of a medication delivery service to vulnerable people in the community.

The most recent patient survey had been undertaken in 2013. The results showed that the majority of patients were very happy with the care and treatments that they received and how they were treated by staff. The practice had responded to the findings of the latest and previous surveys. This included running a campaign to encourage patients to sign up to mobile or electronic methods of communication with the practice and displaying notices in the local shop where information for patients could be displayed.

The staff we spoke with told us they felt able to express their views to the practice manager and GP partners and that any suggestions they had for improving the service would be considered. The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning & improvement

The practice was effective in ensuring its staff performed well and operated within a learning culture. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff received annual appraisals that were relevant, meaningful and driven by objectives. The emphasis in this process was on development, promoting opportunities to learn and improve and on maintaining good clinical practice. This was mirrored in the practice's approach to monitoring quality and performance through the review of significant events and the use of clinical audits. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.