Gorleston Medical Centre

Quality Report

Gorleston Medical Centre
Shrublands Health Centre,
Magdalen Way,
Gorleston
Great Yarmouth
NR31 7BP
Tel: 01493 650490
Website: www.gorlestonandhoptonsurgery.co.uk

Date of inspection visit: 16 October 2014
Date of publication: This is auto-populated when the report is published

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We visited Gorleston Medical Centre on the 16 October 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 and responsive service. There were areas for improvement in relation to leadership at the practice. 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:

- The practice was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- Patients were satisfied with the appointment system and felt they were treated with dignity, care and respect. They were involved in decisions about their care and treatment and were happy with the care that they received from the practice.
- The needs of the practice population were understood and services were offered to meet these.

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

The provider should:

- Ensure that all clinical staff are aware of their responsibilities in relation to the Mental Capacity Act (2005).
- Ensure that there are robust systems for feedback of lessons learnt to the non-clinical staff team following significant events.
- Ensure that there are effective systems of support in place for non-clinical staff.
- Follow their recruitment procedure by ensuring that employment references are documented.
- Ensure that staff who act as chaperones receive appropriate training to undertake this role.

Summary of findings

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. Staff had a good understanding of the types of abuse and their responsibilities in relation to safeguarding. Information was provided to support staff in relation to safeguarding children and adults, although not all staff were aware of the safeguarding adult information folder kept in the practice.

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 for 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 had been identified and planned for. All staff had received an annual appraisal and development plans for all staff had been agreed. We saw evidence of multidisciplinary working.

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 with urgent appointments available the same day. The practice had good facilities and was

Summary of findings

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.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and staff were aware of their responsibilities in relation to this. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place, although these were not all documented. 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 and regular performance reviews. The clinical leadership at the practice was positive. However this was not replicated in the leadership of non-clinical staff. There were no non-clinical staff meetings, and some of the non-clinical staff told us they did not feel supported by the practice. Since our inspection we have been advised by the practice manager that the GP partners agreed to an increase in the administration and reception staff resource.

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 over the age of 75 had a named GP who was responsible for the coordination of their care. 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. There was evidence of effective multidisciplinary working to optimise their health care and also reduce unplanned admissions to hospital

The practice was responsive to the needs of older people, including offering rapid access appointments for those with enhanced needs. The practice also undertook home visits. This included visits to administer the influenza vaccination to patients who were housebound and the elderly. The practice undertook welfare checks on the elderly, especially if they missed clinic appointments.

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 made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had structured reviews at least annually to check their health and medication needs were being met and were led by a GP. These reviews were undertaken for patients who lived in residential care. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.There was a Diabetic Specialist Nurse Clinic held on site to review patients with complex diabetes.

Families, children and young people

Good

Information and advice was available to promote health to women before, during and after pregnancy. Expectant mothers had access to a community midwife who held an antenatal clinic every week at the practice. The physical and developmental progress of babies and young children was monitored and the practice had regular meetings with the health visitors. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as

Summary of findings

individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. There was a private room which was available for mothers to breast feed. We were provided with good examples of joint working with midwives, health visitors and school nurses. The practice visited the local high school once every year to discuss sexual health awareness.

There were two GP partners involved in teaching medical students maternity and child healthcare. This led to better learning and dissemination of good practice in this area.

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 offered continuity of care. The practice was open from 8am to 6:30pm Monday to Friday and pre bookable appointments were available on Thursday evening from until 8pm. Early morning appointments with GPs and nurses were available, as well as the health care assistant for blood tests. Patients could book appointments over the telephone, in person or online. Repeat prescription could also be requested online. The practice was proactive in offering a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients contacted the practice or attended appointments. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

The practice worked closely with Norfolk Mental Health Services. A drug and alcohol clinic was held at the practice. This was led by a

Summary of findings

nurse from the Norfolk Recovery Partnership. We saw evidence of shared care between the GPs at the practice and the nurse. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations A mental health and counselling link worker was available at the practice every week. The GPs had the necessary skills and information to treat or refer patients with poor mental health.

One of the GP partners was the mental health lead with the Clinical Commissioning Group and had advocated guidelines and health services for patients with mental health needs. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The GPs recognised that some patients with mental health needs expressed a strong preference for their usual doctor and so the practice made arrangements to facilitate access to the same treating GP.

Summary of findings

What people who use the service say

We spoke with eight patients during our inspection. All of the patients told us that they were able to get an appointment easily. 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. None of the patients we spoke with had any concerns about the practice.

We collected 23 Care Quality Commission comment cards from a box left in the practice two weeks before our inspection. All of the comments on the cards were positive about the practice. Patients reported that all the staff were friendly and helpful and they were happy with the care that they received from the practice. We received a number of positive comments about the cleanliness and standards of hygiene at the practice. The majority of patients reported that they were able to get an appointment easily, although one patient found booking an appointment was difficult, so they tended to ring on the day and were seen. Another patient said that when they emailed for a repeat prescription they did not always get a confirmation reply.

We spoke with representatives from three care homes where patients were registered with the practice. We were told that the GPs undertook regular planned visits to patients and if a patient needed to see a GP before the planned visit, then a home visit would be undertaken. Patients with long term conditions were reviewed in their home and patients prescribed medicines were reviewed regularly. One representative told us that they thought referrals to other services could be more proactive.

The practice had an active 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 reviewed the patient participation group survey, which was undertaken in February 2014, to which approximately 60 patients had responded. The patient participation group had been involved in developing the questions, analysing the findings and agreeing the areas for improvement. These included advertising on line booking of appointments, improving telephone appointment access at 8am, improved appointment availability and advertising information about the PPG. We saw evidence that these actions had been completed. For example, information was available in the practice waiting room regarding online access for appointments and repeat prescriptions and there was a PPG information board giving further information about the PPG. The nurse telephone triage system for patients requesting an emergency appointment had been positive in managing appointments.

Gorleston Medical Centre has a branch surgery at Hopton. One of the findings of the PPG survey was that patients at Hopton surgery were upset at the enforced closure of the dispensary at Hopton Surgery, due to a pharmacy opening in the village; however there was nothing the practice could do to change this decision.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all clinical staff are aware of their responsibilities in relation to the Mental Capacity Act (2005).
- Ensure that there are robust systems for feedback of lessons learnt to the non-clinical staff team following significant events.
- Ensure that there are effective systems of support in place for non-clinical staff.
- Ensure that employment references are documented.
- Ensure that staff who act as chaperones receive appropriate training to undertake this role.

Gorleston Medical Centre

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 manager specialist advisor.

Background to Gorleston Medical Centre

Gorleston Medical Centre, in the Great Yarmouth and Waveney clinical commissioning group (CCG) area, provides a range of general medical services to approximately 7100 registered patients living in Gorleston and the surrounding villages.

There are three GP partners who hold financial and managerial responsibility for the practice. There is a salaried GP, two practice nurses and a health care assistant. There are also receptionists, administration staff and a practice manager. The practice is a training practice for medical students and qualified doctors who are training to be GPs.

Gorleston Medical Centre has a slightly higher proportion of patients under 18 and a slightly higher proportion of patients aged over 65, 75 and 85 compared to the practice average across England.

Income deprivation affecting children and older people is slightly higher than the practice average across England.

The practice has a branch surgery at Hopton –on-sea, Station Road, Hopton-on-sea, Great Yarmouth, Norfolk, NR31 9BE. We did not visit the branch surgery as part of this inspection.

Outside of practice opening hours a service is provided by another health care provider (South East Health) by patients dialling the national 111 service.

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 spoke with representative from three care homes where patients are registered with the practice. We

Detailed findings

talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced visit on 13 October 2014. During our visit we spoke with a range of staff, including four GPs, a GP trainee, a medical student, two nurses, 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 eight patients who used the practice. We reviewed 23 comments cards where patients had shared their views and experiences of the practice. We spoke with representatives from three residential homes where patients were registered with the practice. We observed how people were being cared for 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

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. These included reported incidents, clinical audits (a process or cycle of events that help ensure patients receive the right care and the right treatment), comments and complaints received from patients, as well as Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts. These alerts have safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer.

We saw that there was a robust procedure in place to ensure that safety information was shared appropriately within the practice. For example MHRA alerts were printed and reviewed by two GP partners and if the alert was relevant to the practice they sent the information to all the partners and the practice manager. These alerts were actioned as appropriate and shared at the clinical meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. There were clear accountabilities for significant event reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. Incidents were recorded, investigated and learning was identified and shared within the practice. These were discussed at monthly clinical meetings and also at weekly partners meetings. The learning from significant events shared with non-clinical staff was done verbally by the practice manager and there was no record that this had occurred.

We looked at nine records of significant event analyses (SEA) which had occurred from February 2013 to October 2014. We saw evidence which demonstrated that the practice reviewed the circumstances of such events and learned lessons from them. For example, we looked at a significant event analysis following a review of a patient's care, where their need for treatment could have been identified earlier. Additional equipment was subsequently purchased for use by the GPs in the practice. The significant events we looked at had been reviewed and discussed in the partners and clinical team meeting as appropriate and the staff we spoke with confirmed this.

Reliable safety systems and processes including safeguarding

Practice training records made available to us showed that all staff had completed safeguarding training to the appropriate level for their role. We asked members of medical, nursing and administrative staff about their most recent training in safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours for safeguarding children. Information relating to safeguarding children was displayed in the consultation rooms; however this was not in place for safeguarding adults. Not all staff we spoke with were aware of where to access information on how to contact the relevant agencies in and out of hours for safeguarding adults. We saw that this information was available in the safeguarding adult's folder, but not all staff we spoke with were aware of this. They told us that if there was a safeguarding adult concern they would refer to the safeguarding lead or speak with any of the GPs.

The practice had dedicated GPs appointed as lead and deputy lead in safeguarding who had been trained and could demonstrate they had the necessary competence to enable them to fulfil this role. All clinical staff were trained to level 3 and all non-clinical staff had received basic level awareness training. Not all the staff we spoke with were aware of who these leads were, although all staff told us they would speak with a GP if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients contacted the practice or attended appointments. The practice also undertook welfare checks on the elderly, especially if they missed clinic appointments. There was a process in place for the follow up of babies and children who had not attended immunisation appointments. These were followed up by phone and by letter and documented on the child's record.

There was a chaperone policy in operation and a notice was displayed in all of the consultation rooms and the waiting area that invited patients to ask if they required such a facility. A chaperone is a person who might be present during a consultation when an intimate

Are services safe?

examination is taking place to ensure that patients' rights to privacy and dignity are protected. Nursing staff were used as a chaperone, although if nursing staff were not available, non-clinical staff undertook this role, but this was rare. However some of the non-clinical staff we spoke with told us they had not undertaken training to perform this role. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor.

Medicines Management.

We found that all medicines stored at the practice, including vaccines and emergency medicines were managed safely. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked, including those intended for emergency use, were within their expiry dates. There was a clear policy for ensuring medicines were kept at the required temperatures from the time they were received, to the time they were used. This was being followed by the practice staff who understood the importance of maintaining these temperatures. They were also aware of the action they would take if the temperatures were out of range. We saw that refrigerator temperatures, which included the minimum and maximum temperatures, were recorded daily. We noted there was no narrative line on the recording form to document any events where the temperature may have changed, for example when rotating stock.

We noted during our inspection that the refrigerators used to store vaccinations were not kept locked and could be accessed by patients or other people who used the building. We raised this with the practice who said they would ensure the vaccinations were stored securely. Following the inspection, we received confirmation from the practice that these were now locked and stored securely.

Information about the arrangements for obtaining repeat prescriptions was made available to patients. This information was displayed in the practice and available on their website. The practice followed national guidelines around medicines prescribing and repeat prescriptions. Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time. Although one patient said that when they emailed for a repeat prescription they did not always get a confirmation reply.

Cleanliness & Infection Control

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

We saw there were cleaning schedules in place and cleaning records were kept that helped the practice to monitor the effectiveness of the cleaning process. The practice had a separate cleaning schedule for clinical equipment, such as electro cardiogram machines (ECG's) and we saw records that these had been cleaned. We saw a recent hand washing and uniform audit that had been undertaken by one of the nursing staff. Patients we spoke with, and received comments from, told us they always found the practice clean and had no concerns about cleanliness or infection control.

We noted that an infection control audit had been undertaken by the clinical commissioning group in March 2014 and the practice had scored 96%. There were no outstanding issues from this audit for the practice to undertake.

The building was owned and managed by another company, who had completed a legionella risk assessment. (Legionella is a germ found in the environment which can contaminate water systems in buildings.) The practice had implemented actions identified as part of the risk assessment. For example the taps were set to flow for three minutes every day.

Are services safe?

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw that the practice was suitably equipped with adequate stocks of equipment and single-use items required for a variety of clinics, such as the diabetes clinic, and procedures, such as minor surgery and ear syringing.

The equipment was in good order. We looked at the records and there was evidence that electrical equipment had been tested for safety in February 2015. Medical equipment had been serviced in January 2014 and calibration had been completed on 18 June 2014.

Staffing & Recruitment

The practice had suitable procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. This included taking employment references. However although these had been obtained, a copy was not available in the staff file. One of these was a verbal reference which had not been documented and the other was electronic and had not been printed. All clinical and non-clinical staff had a criminal record check through the Disclosure and Barring Service. Checks made through the Disclosure and Barring Service help to ensure a person's suitability to work with vulnerable patients. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

Some of the staff we spoke with told us that they did not feel there were sufficient administration and reception staff. There had been some changes within this group of staff recently. Since our inspection we have been advised by the practice manager that the partners agreed to an increase in the administration and reception staff resource.

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. This included for example, checks of the building, checks of emergency medicines and checks of medical equipment. The building was owned and managed by another company who had a health and safety policy in place which was followed by the practice. The practice completed a health and safety risk assessment of their parts of the building at least annually and this was feedback to the managing company for actions to be agreed. A fire risk assessment had been completed by the managing company and the practice staff were aware of their responsibilities regarding fire safety. The practice had recently undertaken a fire drill which was reported to have gone well and areas of responsibility for checking certain areas of the building were reiterated.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included for example, loss of premises and unplanned GP sickness. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system. We were advised that two copies were kept off site. This plan was reviewed annually.

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The practice carried a stock of medicines for use in the event of a medical emergency. All staff asked knew the location of this equipment and medicines and records confirmed these were checked monthly to ensure they were within their expiry dates. We noted during our inspection that the emergency medicines could be accessed by patients or other people who used

Are services safe?

the building. We raised this with the practice who said they would review the storage of the emergency medicines. Following our inspection, we received confirmation from the practice that these were now stored securely.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice used National Institute for Health and Care Excellence (NICE) guidance to ensure the care they provided was based on latest evidence and was of the best possible quality. Information, new guidance and changes to current guidelines was made available to and shared with staff by email notifications and during staff meetings.

The practice had dedicated GP leads in specialist clinical areas such as diabetes, end of life care, minor surgery, maternity and children and substance misuse. The practice nurses supported this work which allowed the practice to focus effectively on the care and treatment needs of patients with a range of specific conditions. Healthcare assistants' skills and knowledge was developed to help support the practice.

The practice had a number of well-established clinics for conditions such as asthma and diabetes and for adult and baby immunisations. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and a dedicated smoking cessation clinic.

There were a range of services offered at the practice in order to meet the needs of the patients. These included for example, a drug and alcohol clinic led by a nurse from the mental health trust. We saw evidence of shared care between the GPs and the nurse. A mental health link worker was also available for patients one day per week. There was also a Diabetic Specialist Nurse Clinic held on site to review patients with complex diabetes.

One of the GPs worked closely with the Clinical Commissioning Group (CCG), who visited regularly to feedback the performance of the practice. We saw that the practice was prescribing a higher percentage of first choice anti-depressants, compared to other practices in the CCG area, which was positive.

Management, monitoring and improving outcomes for people

We saw evidence of continued improvement to the service provided which resulted in positive outcomes for patients.

The practice had a system in place for completing clinical audit cycles. Clinical audit involves reviewing the delivery of healthcare to ensure that best practice is being carried out.

We looked at three completed clinical audit cycles. One related to the treatment of urinary tract infection in female patients. This identified that female patients with a urinary tract infection were prescribed the appropriate medication. Another related to the use of medicines in dementia care and the appropriate review of patients. Findings had been shared with staff and actions and recommendations had been recorded. There was documented evidence that this audit had been reviewed, so the practice was able to confirm the actions identified had been implemented successfully. We saw an improvement in the number of patients prescribed medicines for dementia, who had been reviewed appropriately. We also saw three single audits, which were ready for re-audit. One of these was regarding contraception following termination of pregnancy.

Two GPs in the practice carried out minor surgical procedures, in line with their CQC registration under the Health and Social Care Act (2008) and NICE guidance. One GP we spoke with told us that they undertook minor surgery approximately twice per month and joint injections more frequently in routine clinics. We saw that an audit had been completed in 2013 and a further audit was being undertaken at the time of the inspection.

Effective staffing

All new staff underwent a period of induction to the practice. There was a health and safety induction checklist, which covered health and safety, fire and first aid. We saw evidence that these had been completed. New staff had to read and sign that they have read the Staff Handbook, Confidentiality Policy and the Health and Safety Policy and the protocol folder. The staff we spoke with confirmed that this had happened.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We noted from the records that one member of staff had not had an annual appraisal however the date for this had been scheduled. Staff interviews confirmed that the practice was proactive in encouraging and providing training and funding for relevant courses, for example one member of staff was undertaking a leadership course and another was undertaking a National Vocational Qualification (NVQ). As the practice was a training practice,

Are services effective?

(for example, treatment is effective)

doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

We were told by a number of staff that the practice participated in 'time to learn' sessions three times a year. Training was arranged by the Clinical Commissioning Group (CCG) or training was undertaken within the practice according to the needs of the practice staff. We saw that clinical staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Nursing staff told us that they had personal development plans and in addition to their mandatory training they were supported to attend study days each year to undertake training in areas of their specialist interest.

Working with colleagues and other services

We found that the practice engaged regularly with a range of health and social care providers in the area. The practice 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 lead GP, palliative care nurse, district nurses, community matron and Macmillan nurse. Decisions about care planning were documented in a shared care record.

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patents. These meetings were attended by the GP, social services, community matron, physiotherapy, admission prevention team, rehabilitation therapist, neurology nurse, mental health, first response, integrated care coordinator and the East of England Ambulance Service.

The practice was participating in a hospital admission avoidance pilot scheme. This involved the GPs meeting monthly with the community matron and district nurses. Ante natal care was provided by a midwife, who held a weekly clinic at the practice. There was no formal meeting with the midwife but there was a regular meeting with the health visitor.

We saw that there were information leaflets and posters in the waiting areas. This literature contained up to date information and contact details for local health and care services, such as domestic abuse and crossroads care support. 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.

Information Sharing

Records we saw showed that multidisciplinary meetings took place at the practice with a range of other health professionals in attendance, to co-ordinate care and meet the needs of the patients. We saw that information was shared appropriately between the agencies involved. For example 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. 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.

The practice used an established electronic patient records management system (known as EMIS) to provide staff with sufficient information about patients. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk. For example, for patients who were caring for others, the caring responsibility was marked on the summary record of a patient when they attended the practice as a patient in their own right so that the social and psychological factors associated with caring for others could be addressed in care planning.

The electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

We saw that all patient correspondence, including out of hours reports, was reviewed by two partners at the practice and actioned as appropriate. When possible these were reviewed by the patient's usual GP to ensure continuity of care for patients. There was not a robust audit trail for the actions that had been agreed, as these were sometimes communicated using loose notes which could be lost. We spoke with the provider about this and they agreed to review this process to ensure there was a clear audit trail of actions to be taken.

Are services effective?

(for example, treatment is effective)

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, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients that we spoke with and received comments from confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. The practice nurse confirmed written consent was always obtained from parents prior to immunisations being given. They confirmed the consent they would obtain if the child was looked after by the local authority. Staff understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We saw the practice's Mental Capacity Act (MCA) (2005) policy. The Mental Capacity Act (MCA) (2005) is used for adults who lack capacity to make specific decisions. The practice policy provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. Most of the clinicians we spoke with were aware of the requirements of the Mental Capacity Act (2005).They understood the key parts of the legislation and were able to describe how they implemented it in their practice. However, this knowledge was not shared by all of the clinicians we spoke with.

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

There was a large range of up to date health promotion information available at the practice and on the practice website with information to promote good physical and mental health and lifestyle choices. Information about mental health and domestic violence advice and support was prominently displayed in waiting areas with helpline numbers and service details.

Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. There was information about services to support them in doing this, such as smoking cessation and weight management advice. Smoking cessation sessions with the nurse or the health care assistant were available and could be made during usual consultation times. Longer appointment times of 20 minutes were allocated for smoking cessation consultations. A health trainer was available every week. The health trainer provided advice and support to maintain and improve health, for example smoking cessation and weight management. Well men clinics were also available at the practice. Once every year the practice visited the local high school to discuss sexual health awareness.

We saw that new patients were invited into the surgery when they registered to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a health care assistant. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP.

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. The practice proactively identified people who needed extra support in relation to health promotion and the prevention of ill-health. For example, the practice undertook home visits to patients who were housebound and the elderly to administer the influenza vaccination. Through discussion with staff and from records viewed we saw that the practice performed well and had a high uptake for both childhood and adult immunisation and vaccinations.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in offering additional help. For example, the practice kept a register of all patients with a learning disability and offered an annual health check. At the time of our inspection 24 of the 51 patients with a learning disability had attended for an annual health check. The practice also identified patients who were also carers. Staff and clinicians were automatically alerted to patients who were also carers. This ensured that doctors were aware of the wider context of the patients' health needs. Information was available for carers in the practice and on the practice website.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

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

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 with clinical and non-clinical staff members. Information was on display to inform patients of this. There were signs in the waiting areas and consulting rooms explaining that patients could ask for a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so.

The practice was easily accessible to patients with mobility issues. Corridors leading to consulting and treatment rooms were suitable for wheelchair access. There were accessible toilets, baby changing facilities and a private room which mothers could use when breast feeding.

We looked at data from the 2014 National GP Patient Survey. We noted that 92% of patients stated they would recommend the practice. 89% of patients reported that the reception staff were helpful with 68% 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 (83%) and by their doctor (85%). 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 2014 National GP Patient Survey showed that 84% of patients felt the GP was good giving them enough time, 88% felt that the GP was good at listening to them and 82% felt that the GP was good at explaining test results to them. 74% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were lower than the average for the local Clinical Commissioning Group (CCG) area. The corresponding figures for the nursing staff provided a similar picture although they were rated higher than the CCG average for listening and involving people in decisions about their care.

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 and patients told us that their views were listened to.

Patient/carer support to cope emotionally with care and treatment

The 2014 National GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. The practice were rated above the national average for the proportion of patients who stated that the last time they saw or spoke with a GP or nurse they were good or very good a treating them with care and concern. The patients we spoke with, and received comments from, expressed that they were supported or would be supported, if this was necessary, to cope emotionally with care and treatment by staff at the practice. For example one patient we spoke with explained how they were supported emotionally in relation to their long term condition.

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

New patients who registered at the practice were asked if they had a carer and if their carer was registered at the practice. They were also asked if they were a carer and if the person they cared for was registered at the practice. This information was put onto the patient's record to alert practice staff so that appropriate support could be given.

Are services caring?

Information was available in the waiting room and on the practice website, which sign posted people to a number of support groups and organisations for carers. The practice had a 'carer support worker' who visited one morning every week to offer support and advice on issues such as benefits, the carer's needs and where to go for help.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and took appropriate steps to tailor its service to meet these needs. The practice worked collaboratively with other agencies such as local mental health, alcohol and substance misuse services and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) For example information was available in the practice waiting room regarding online access for appointments and repeat prescriptions and there was a PPG information board giving further information about the PPG. The nurse telephone triage system for patients requesting an emergency appointment had been positive in managing appointments.

Patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this prevailing view of the responsiveness of the practice.

Tackling inequity and promoting equality

The location had level access throughout for patients who used wheelchairs as well as wider doors and accessible toilets. There were automatic doors to assist patients with mobility needs or with children in pushchairs, to gain easy access. We received positive feedback from patients about the premises being accessible.

The practice had access to a telephone translation service for patients who did not have English as a first language, although we were told they had not needed to use it. Staff we spoke with were aware of how to access this if it was needed.

There was a system to highlight vulnerable patients on the practice's electronic records. This helped to ensure staff were aware of any relevant issues when patients contacted the practice or attended appointments.

Access to the service

Comprehensive information was available to patients about appointments on the practice website and in the practice patient information leaflet. This included how to arrange on the day and book in advance appointments, which could be booked up to one month in advance. Information on requesting a home visit, requesting a telephone call back from a GP, nurse triage appointments and how to book appointments through the website was also provided. Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The practice had developed an appointment system which was responsive to the needs of patients. The practice was open from 8am to 6:30pm Monday to Friday and pre bookable appointments were available on Thursday evening from 6:30pm until 8pm. This improved access for those patients who worked during usual office hours. School age children were able to make appointments outside of school hours. Patients were able to choose whether they saw a male or female GP. Patients could book appointments over the telephone, in person or by registering to use an online facility. Repeat prescriptions could also be requested on line.

The 2014 National GP patient survey results showed that 86% of patients were satisfied with the practice's opening hours and 95% of patients said that they found it easy to get through on the telephone. 97% of patients said the last appointment they had was convenient. These results were above average for the Clinical Commissioning Group (CCG) area. However, 80% of patients described their experience of making an appointment as good, which was below the average for the CCG area. The practice was aware from the patient participation group survey, undertaken in February 2014, that areas for improvement in relation to making appointments included, advertising the on line booking of appointments, improving telephone appointment access at 8am and improved appointment availability. The practice had implemented a number of actions to improve this area. For example, the nurse telephone triage system for patients requesting an emergency appointment had been positive in managing appointments and advertising how to obtain online appointments.

Are services responsive to people's needs?

(for example, to feedback?)

On the day of our inspection, the majority of the patients we spoke with and received comments from, reported that they were able to get an appointment easily, although one patient found booking an appointment was difficult, so they tended to ring on the day and were seen. Staff we spoke with confirmed that if a patient was unwell they would get an urgent appointment. They confirmed that children who needed to be seen urgently would also be seen.

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. None of the patients spoken with had ever 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.

Are services well-led?

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

Our findings

Vision and Strategy

The practice patient information leaflet included the statement, 'We have a superb team of nurses, health visitors, reception and admin staff who are committed to the ethos of the NHS. But while our facilities are modern, our values are traditional, where patients' needs come before costs.' The staff at the practice shared a desire to provide patients with an effective, caring and responsive service where patients' needs did come first. Throughout our visit we saw a kind, caring and compassionate approach to patients.

Governance Arrangements

The practice had dedicated GP leads responsible for governance. There were clearly identified GP lead roles for areas such as complaints, safeguarding and information governance. These responsibilities were shared between the GP partners. Clinical staff also had lead roles in relation to their clinical expertise. For example there was a nurse lead for asthma, diabetes and chronic obstructive pulmonary disease (COPD) and GP clinical leads for areas such as diabetes, minor surgery and end of life care. The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice. It was clear that staff could go to any of the GPs for advice regarding any of these roles.

There were arrangements for learning from incidents, significant events and complaints and appropriate changes were implemented to help to prevent them occurring again. We did not see evidence of any review of significant events analyses, to identify trends, although this had been undertaken for complaints.

Leadership, openness and transparency

There was a sense of collective leadership between all the GP partners. There was a clear leadership structure where the partners led and worked well together. We were told by the GP partners that there was a weekly GP partners meeting, which included discussion of safety, risk and quality issues. However these meetings were not documented. We were also told by one of the GP partners that there should be practice team meetings quarterly but that these had not happened recently. We saw that there had been a practice team meeting on the 30 September 2014, however the meeting previous to this was December 2013.

Monthly GP clinical meetings were held and also monthly clinical meetings with the GP, nurses and the health care assistant. The clinical staff we spoke with felt supported by the practice and commented on the clinical support they could easily obtain from the GPs. We saw evidence that the clinical leadership at the practice was positive, however this was not replicated in the leadership of non-clinical staff.

There were no non-clinical staff meetings and some of the non-clinical staff who we spoke with did not feel supported. There was no formal, documented feedback mechanism to this staff group. For example lessons learned from significant events were passed on by the practice manager verbally. We fed this back to one of the GP partners who agreed to discuss this further with the partners to agree how this group of staff could be further supported. Since our inspection we have been advised by the practice manager that the GP partners agreed to an increase in the administration and reception staff resource.

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

The practice had gathered feedback from patients through patient surveys, suggestions and complaints. The practice had an active patient participation group (PPG) which met every two months. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. The PPG undertook a survey in February 2014. The areas identified for improvement were advertising on line booking of appointments, improving telephone appointment access at 8am, improving appointment availability and advertising information about the PPG.

There was an action plan in place to make improvement to these areas and we saw evidence that these actions had been completed. For example, information was available in the practice waiting room regarding online access for appointments and repeat prescriptions and there was a PPG information board giving further information about the PPG. The nurse telephone triage system for patients requesting an emergency appointment had been positive in managing appointments. The results and actions agreed from these surveys were available on the practice website. The PPG representatives we spoke with told us that they felt able to express their views to the practice and that any suggestions they had for improving the service were taken seriously.

Are services well-led?

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

Patients were able to feedback their suggestions via a 'suggestion box' in the waiting area or were encouraged to write to the practice manager. Information regarding these methods of feedback were provided in the practice patient information leaflet.

Staff were aware of how to raise suggestions and concerns and all of the staff we spoke with said that they would feel confident to do this and would be listened to. The practice had a whistle blowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. However not all the staff we spoke with were aware of this policy.

Management lead through learning & improvement

The practice had a culture which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received annual appraisals where their learning and development needs were identified and planned for. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality, safe and effective care. Clinical staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We reviewed three staff files and saw that regular appraisals had been undertaken and included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice and there was a strong focus on clinical excellence and training and support for clinical staff. There were two GP partners involved in teaching medical students maternity and child healthcare, which led to better learning and dissemination of good practice. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed.

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.