Dr Noakes and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Noakes and Partners also known as The Park Surgery on 10 November 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing caring, responsive and well-led services. We found the practice to be good for offering safe and effective services.

In addition we found the practice to be outstanding for providing services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances might make them vulnerable and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

- In response to the high rates of teenage pregnancy and termination of pregnancy (TOP) rates in the area, one GP had trained to fit intrauterine coil devices and contraceptive implants. As a result the practice had seen a 60% decrease in the number of patients undergoing TOPs since 2011.

Summary of findings

- Patients who did not attend for bowel and breast screening were identified by the practice and written to with supporting information to ensure they were able to make a clear and informed choice. In addition patients who did not attend for cervical screening were personally telephoned by the practice manager in the early evening to ensure they had received the information to make an informed and valid choice.
- The practice had a health trainer to support weight management, alcohol reduction and smoking cessation and could demonstrate this had a positive impact for patients using this service.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was safe and is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report significant events or other incidents. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and there were effective arrangements to identify and respond to potential abuse. Medicines were managed safely and the practice was clean and hygienic. Staff were recruited through processes designed to ensure patients were safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it liaised with other local providers to share best practice.

The practice had developed additional evidence based templates to cover non quality outcome framework (QOF) areas to ensure patients received the best care. An example was patients with an elevated blood glucose level but not diagnosed as diabetic or pre-diabetic. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. We observed a patient-centred culture. Patients rated the practice higher than others for all aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained their confidentiality.

Summary of findings

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with their GP or a GP of choice and that there was excellent continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led. It had a clear vision with patient focus and quality as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of patient and staff satisfaction. The practice gathered feedback from patients using a number of external agencies, and it had an active virtual patient representation group (PRG) which influenced practice development.

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

Outstanding ☆

The practice is rated as good for safe and effective services and outstanding for caring, responsive and well led services for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice provided weekly GP visits to local care homes. The practice worked to try to reduce poly-pharmacy in patients and had met with the manager at one home and was able to reduce medication significantly as a result. A meeting was scheduled with a second care home to do the same.

GPs administered a lot of flu vaccinations to patients opportunistically and flu vaccination rates were in line with national averages. A local support service had attended the practice for a fortnight to promote the Message in a Bottle initiative, this was a scheme for anyone living at home that ensured vital information was available to identify them and to give advice of their medication and recent illness for the emergency services.

The practice contacted those patients who did not attend for their vaccination and the practice nurses visited care homes and house bound patients to administer vaccinations. This also gave an opportunity for chronic disease monitoring for those patients.

The practice took part in the Avoiding Unplanned Admissions direct enhanced service contract (DES). One GP partner helped to implement this service for the local clinical commissioning group.

People with long term conditions

Outstanding ☆

The practice is rated as good for safe and effective services and outstanding for caring, responsive and well led services for the care of patients with long term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when required. All these patients have a named GP and a structured annual review to check that their health and medicine 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 was available when needed.

Summary of findings

A phlebotomy service was provided from the practice each morning and had recently been extended to early afternoons to support patient access.

The practice achieved high QOF scores and had a principle of rarely excepting patients from QOF. In addition the practice had developed a suite of searches that were run at least three monthly to target conditions and patients not identified by QOF indicators and registers. Clinical audits were used to improve the outcomes for patients with long term conditions.

The practice nurses worked with patients to manage long term conditions and recalled patients with conditions such as asthma and diabetes. The nurses maintained their training in this area to ensure they complied with best practice and the most recent guidelines. The nurses did not run long term condition clinics, and appointments could be made at any time to suit the patients' needs and lifestyle rather than waiting for pre-set clinics. One GP utilised a risk profiling computer search software weekly to identify patients who had a high risk of hospital admission, overdue screening or were put at risk because of their medications. The evidence from these searches was used to inform clinical management of these patients and ensure their safety.

Families, children and young people

Outstanding ☆

The practice is rated as good for safe and effective services and outstanding for caring, responsive and well led services for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The GP lead for safeguarding and the practice manager worked closely with the health visitor and other agencies. The practice had very high levels of deprivation and a significant number of children on the child protection register. As a result the practice worked hard to ensure they were kept up to date with their patients and tried to maintain high immunisation rates. The practice manger routinely liaised with the health visitor each month to check the list of 'at risk' patients and to let her know which children required immunisations or were a new addition to the child protection register.

Childhood immunisation rates for the vaccinations given were higher than local CCG averages. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the

premises were suitable for children and babies. The practice had identified a gap in the sexual health service in the area and services had been developed to improve access to advice and support, particularly for young people.

All new-borns and their mothers were sent an invitation for a six week check with their GP. There were a number of positive comments about the care and treatment of children and young babies in respect of access to urgent appointments and the caring attitude of reception and clinical staff. Great Yarmouth continues to have a major problem with very high teenage pregnancy and Termination of Pregnancy (TOP) rates. In response to this, four years ago, one GP trained to fit intrauterine coils and contraceptive implants and as a result the practice had seen a dramatic reduction of 60% in patients undergoing TOPs since 2011.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as good for safe and effective services and outstanding for caring, responsive and well led services for the care of working age patients (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 continued to work to maintain good access. In addition they offered clinical telephone access, from 11 am and would phone patients back if necessary**.** Pre bookable extended hours surgeries were available twice a week aimed at patients unable to attend during normal working hours.

The practice offered a number of online services, including booking and cancelling appointments and requesting repeat medicines. They also provided a full range of health promotion and screening clinics that reflected the needs of this age group. The practice encouraged patients to book appointments and repeat medications on-line. We were told prescriptions were usually available by midday one working day after requesting. The practice had also introduced the electronic prescribing system achieving nearly an 80% uptake rate since introduction. GPs did their own prescription requests regularly during the day, so usually the prescription was with the chemist within a few hours of being requested.

The practice offered routine health checks with nurses for those patients between the ages of 40 – 74 years, which could be booked at any time and as of September 2015 all appropriate patients in this age group had been offered a check within the previous five years by the practice. Cervical smears could also be booked at any time with

the practice nurses. Patients who did not attend for bowel and breast screening were identified by the practice and written to with supporting information to ensure they were able to make a clear and informed choice. In addition patients who did not attend for cervical screening were personally telephoned by the practice manager in the early evening to ensure they received the information to make an informed and valid choice. The practice uptake for cervical smear attendance was 81.6%, which was comparable to the national average of 81.88%. The practice nurses had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions. Appointments for these areas could be made at any time as opposed to specific clinics to ensure patients were able to make appropriate appointments at a time that suited them.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as good for safe and effective services and outstanding for caring, responsive and well led services for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Annual health reviews were completed for these patients and care and treatment could be provided in the patient's own home where this was beneficial and assisted in engaging patients to have appropriate care.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. There were robust systems in place to safeguard children and adults whose circumstances might make them vulnerable. The child protection lead had initiated quarterly practice meetings which were attended by all GPs along with the local midwife and health visitor; during these the practice reviewed families on the child protection register. Vulnerable adults were discussed at clinical governance meetings. GPs took the responsibility to ensure the correct coding of all clinical data including families and children on the child protection register. The practice computer system had been set up to ensure patients records were flagged to alert staff that a patient was on a vulnerable patient register. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

The practice maintained a register of patients with learning disabilities and aimed to carry out health checks on them annually. Those patients who did not attend were contacted and of the 95 patients on the register 90 had received a learning disability health check in the previous 12 months.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as good for safe and effective services and outstanding for caring, responsive and well led services for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. All GPs were up to date with mental capacity training and the practice actively screened patients for dementia where appropriate. We saw that since 1 April 2015 the practice had screened 274 patients.

There was a high incidence of mental illness in Great Yarmouth and alcohol and drug dependence were a common issue. The practice actively worked to decrease the use of tranquilizer medicine, ran regular searches on patients prescribed medicines used for the treatment of bi-polar disorder, or serious mental health conditions and liaised with the Mental Health Trust to ensure these patients were being monitored. We were told the practice had lost their mental health worker due to a lack of resources within the local Mental Health Trust. Replacements had been requested by the practice and we were advised that two new liaison workers had recently been allocated to the practice. The practice told us they would continue to monitor the effectiveness of this situation.

The practice carried out annual health checks on patients with serious mental health conditions and we saw that 95% of these patients had received an annual health and medicine review in the previous twelve months.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing above local and national averages. There were 106 responses and a response rate of 39%.

- 98% find it easy to get through to this surgery by phone compared with a CCG average of 81% and a national average of 73%.
- 96% find the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 81% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 66% and a national average of 60%.
- 95% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 98% say the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.
- 93% describe their experience of making an appointment as good compared with a CCG average of 79% and a national average of 73%.
- 92% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 63% and a national average of 65%.
- 85% feel they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 43 comment cards which were all extremely positive about the standard of care received. Staff including nurses and GPs received specific praise for their professionalism, kindness and care. Patients reported that they felt listened to and involved in decisions about their treatment and were treated with compassion. These findings were also reflected during our conversations with patients during, and after, our inspection. We spoke with seven patients during our inspection. The feedback from patients was extremely positive. Patients told us about the ability to speak or see a GP on the day and where necessary get an appointment when it was convenient for them with the GP of their choice. We were given clear examples of effective communication between the practice and other services. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing, reception and the management teams were all very approachable and supportive. Patients felt confident in their care and liked the continuity of care they received at the practice. The patients told us they felt their treatment was professional and effective and they were very happy with the service provided. We also spoke with members of the PRG who told us they could not fault the care they had received. We spoke with visiting health care professionals and the manager of a neighbouring care home who reiterated and confirmed patient feedback.

Outstanding practice

We saw several areas of outstanding practice including:

- In response to the high rates of teenage pregnancy and termination of pregnancy (TOP) rates in the area, one GP had trained to fit intrauterine coil devices and contraceptive implants. As a result the practice had seen a 60% decrease in the number of patients undergoing TOPs since 2011.
- Patients who did not attend for bowel and breast screening were identified by the practice and written to with supporting information to ensure they were able to make a clear and informed choice. In addition patients who did not attend for cervical

screening were personally telephoned by the practice manager in the early evening to ensure they had received the information to make an informed and valid choice.

- The practice had a health trainer to support weight management, alcohol reduction and smoking cessation and could demonstrate this had a positive impact for patients using this service.

Dr Noakes and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a practice manager specialist adviser and a second CQC inspector.

Background to Dr Noakes and Partners

Dr Noakes and Partners also known as The Park Surgery provides general medical services to approximately 10,600 patients in the mainly urban areas of Great Yarmouth and the suburban areas of Gorleston and Bradwell. Treatment and consultation rooms are situated on the ground and first floor. There is a lift and a stair lift available for patients to access the first floor waiting area and treatment rooms. Parking is available with level access and automatic doors.

The practice has a team of seven GPs meeting patients' needs. All seven GPs are partners, meaning they hold managerial and financial responsibility for the practice. GPs run personal lists but patients are given the option to see a GP of their choice. There is a team of two practice nurses, and two health care assistants who run a variety of appointments for long term conditions, minor illness and family health.

There is a practice manager and a team of non-clinical administrative, secretarial and reception staff who share a range of roles, some of whom are employed on flexible working arrangements. Community midwives run sessions three times a week at the practice and a health trainer provides two sessions per week. The community matron, a specialised diabetic nurse and the district nursing team also attend the practice. In addition there is a team of cleaners employed to oversee the practice cleaning. The practice is a long standing teaching and training practice.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.00am and 6.30pm, Monday to Friday. Appointments are from 8.30am every morning to 11am and from 2.30pm to 5pm. if the appointments are full the surgeries are often extended to ensure all patients could see their own GP on the same day. Pre-bookable extended hours surgeries are offered Tuesday and Thursday mornings between 7am and 8am for working patients who are unable to attend during normal opening hours. In addition to pre-bookable appointments that could be booked from three to six months in advance, urgent appointments are available for people who need them.

Outside of these hours, the out of hours provider is a professional medical agency commissioned by the Great Yarmouth & Waveney Clinical Commissioning Group (Healtheast). Primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

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

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

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

The inspection team :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC's intelligent monitoring systems.
- Carried out an announced inspection visit on 10 November 2015.
- Spoke with staff and patients.
- Spoke with members of the patient participation group.
- Spoke with staff from a local care home.
- Spoke with visiting health professionals.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All relevant complaints received by the practice were entered onto the system and automatically treated as a significant event. The practice carried out an analysis of all complaints and significant events.

Staff we spoke with could give examples of learning or changes to practices as a result of complaints received or incidents. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all staff working at the practice were trained in safeguarding and were aware of the procedures should there be concerns. New safeguarding concerns were discussed as a regular topic on the Clinical Governance meeting agenda, and referrals were logged as critical incidents.
- A notice was displayed in the waiting room, advising patients that nurses and trained staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The name of the member of staff was recorded in the patients' medical record. In addition when a patient declined a chaperone this was noted in the record.
- There were a range of comprehensive procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who oversaw on-line infection control updates and liaised with the local infection prevention teams to keep up to date with best practice. The practice was working towards the local CCG Gold Standard for Infection Control. We reviewed an infection control audit undertaken by the CCG in February 2015. Recommendations had been set out in an action plan and the practice was working to implement these. We saw that infection control flow charts were displayed in consultation and treatment rooms. There was a log of daily infection control activity undertaken in each room. There was an infection control protocol in place and staff had received up to date training. We saw evidence that action had been taken to address any improvements identified from the audit and daily observations.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of

the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. We were told the practice had always been low, cost effective prescribers. One partner always attended the monthly CCG prescribing meetings. One GP regularly ran searches to pick up high risk drug combinations, results or other markers so that the practice could act on them and intervene. The practice had appropriate written procedures in place for the production of prescriptions that were regularly reviewed and accurately reflected current practice. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We saw processes in place for managing national alerts about medicines, such as safety issues. Records showed that the alerts were distributed to relevant staff and appropriate action taken. There was a clear system for managing the repeat prescribing of medicines and a written risk assessment about how this was to be managed safely. Patients were able to phone in for repeat prescriptions, as well as order on line, in person, by post or via a chemist, and have their script within 24 hours. The practice had introduced electronic prescribing speeding up the process further. Changes in patients' medicines, for example when they had been discharged from hospital, were checked by the GP who made any necessary amendments to their medicines records. This helped ensure patients' medicines and repeat prescriptions were appropriate and correct. We checked treatment rooms, medicine refrigerators and GPs' bags and found medicines were safely stored with access restricted to authorised staff. Suitable procedures were in place for ensuring medicines that required cold storage were kept at the required temperatures. Stocks of controlled drugs (medicines that have potential for misuse) were managed, stored and recorded properly following standard written procedures that reflected national guidelines. Processes were in place to check medicines were within their expiry date and suitable for use. Out of date and unwanted medicines were disposed of in line with waste regulations. Blank prescription forms and paper were handled according to national guidelines and were kept securely. Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced in line with national guidance. PGDs were up to date and there were clear processes in place to ensure the staff who were named in the PGDs were competent to administer vaccines.

- Records we looked at contained evidence that appropriate recruitmentchecks had been undertaken prior to staff's employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). 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. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including GPs, nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Systems were in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. Clinicians ensured these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Clinical staff we spoke with told us about the daily clinical meetings/coffee breaks where issues and concerns could be addressed with colleagues. We saw that staff were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. We saw that this also took place during clinical meetings and the minutes we reviewed confirmed that this took place. Clinical staff we spoke with were open about asking for, and providing colleagues with, advice and support. We saw that where a clinician had concerns they would telephone or message another clinician to confirm their diagnosis, treatment plan or get a second opinion.

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

The practice had comprehensive systems in place to manage patients who were either about to access or had accessed secondary care (hospital). The practice was proactive in monitoring referrals to and reviewing patients recently discharged from secondary care. For example, the practice followed up a two week referral, after three days of making the referral to make sure it had been received and an appointment confirmed. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 96.4% of the total number of points available, with 6.4% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed;

- Performance for diabetes related indicators was worse in comparison to the CCG and national average. With the practice achieving 86% this was 4.8 percentage points below the CCG average and 3.2 percentage points below the national average. We discussed these figures with the practice, the practice had an ethos to not except patients from QOF, (where appropriate a practice may except a patient from a QOF indicator, for example, where patients decline to attend for a review, or where a medication cannot be prescribed due to a contraindication or side-effect), however continued to encourage attendance from these patients for health and medication review to ensure they were not overlooked.
- Performance for asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypertension, learning disability, mental health, osteoporosis, palliative care, peripheral arterial disease, rheumatoid arthritis and stroke and transient ischemic attack were all above or in-line with CCG and national averages with the practice achieving 100% across each indicator.
- Performance for secondary prevention of coronary heart disease indicators were above in comparison to the CCG and national averages with the practice achieving 95.6%. This was 0.5% above CCG and 0.6% above national averages.

Good

Are services effective?

(for example, treatment is effective)

- The percentage of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was comparable to local CCG averages and below national average.

  Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to ensure improved care, treatment and outcomes for patients. The practice conducted a number of clinical audits, we looked at three. All were completed audits where the improvements made had been implemented and monitored. For example; an audit of prescribing of the combined oral contraceptive (COC) pill and obesity in female patients. The practice reviewed COC prescribing in obese female patients. The object being to identify all patients between the ages of 15 and 49 with an increased body mass index on COC in the previous 12 months. 20 out of 33 patients were included in the study. The practice ascertained their compliance with the UK medical eligibility criteria for contraception use (UKMEC) and where appropriate suggested change from COC to long acting reversible contraception or the progesterone only pill. Patients were written to or advised during face to face consultation. Results were analysed and discussed in clinical meetings and learned from. This was then re-audited three months later. A letter of invitation was sent to those patients identified in the original audit for review. Results showed that despite the short period of the re-audit a positive change was already observed with no new patients in the UKMEC category identified. Other audits included the monitoring of patients prescribed anti-inflammatory drugs and kidney function testing and the use of medicines used to reduce gastric acid production in care home residents to ensure long term use was appropriate and recorded effectively. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services.

Effective staffing

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had an induction programme for newly appointed clinical and non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. This was followed up with an end of probation assessment and a six months competency assessment review.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, and appraisals, coaching and mentoring.
- Clinical supervision and support for training GPs included peer review and input from each of the GP partners, with open discussion and initiation of any identified training needs.
- The practice was working to support the facilitation and revalidation of doctors and nurses. All staff had undergone an appraisal within the last 12 months.
- Staff received training that included: safeguarding, complaints, health and safety, chaperoning, infection control, fire procedures, basic life support, equality and diversity and information governance awareness. Staff had access to and made use of e-learning training modules, practice away days and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results.

Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and were attended by community services and other health services. We saw that care plans were routinely reviewed and updated at these meetings.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that staff had a clear understanding of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. There was a register of learning disability patients who were invited for an annual health check with their GP; the learning disability community nurse was informed of those who failed to make an appointment. We saw that of the 95 patients on the practice learning disability register, 90 had received a health check and their care plans had been reviewed within the last year.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent. We were told where there was doubt the procedure was delayed until the consent issue could be clarified.

Health promotion and prevention

Patients who might be in need of extra support were also identified by the practice. These included those at risk of developing a long-term condition and those requiring support in other areas such as the homeless, benefits and/or housing. Patients were signposted to the relevant service. We saw examples of vulnerable homeless patients who were provided support from the practice as their only point of contact. Patients who were in need of extra support were identified by the practice and appropriately referred. For example to outreach substance dependency services or family planning.

The practice had a comprehensive screening programme. The practice wrote to all its patients who failed to attend national screening programmes for bowel and breast cancer, to encourage their attendance and to provide information to ensure patients were able to make an informed choice. In addition the practice manager ran a regular audit of patients who did not attend for their cervical screening test and personally telephoned patients in the early evenings to ensure patients who were not available during working hours received a personalised telephone call and the information to enable them to make a decision as to whether to attend for screening. The practice's uptake for the cervical screening programme was 81.6%, which was comparable to the national average of 81.88%. All GPs offered smoking cessation advice and treatment as do the nurses and health trainer.

Childhood immunisation rates for the vaccinations given were above CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 100% and five year olds from 87.3% to 93.7%. With meningitis C vaccine uptake at 0.9% compared to the CCG average of 0.3%. Flu vaccination rates for the over 65s were 73.8%, and at risk groups 62.82%. These were also comparable to national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74, as of September 2015 all appropriate patients in this age group had been offered a check within the previous five years. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. A community diabetic specialist nurse attended the practice monthly to assist patients with diabetes who required a higher level of support with their treatment.

The practice had a high level of consideration for the care of its patients with long term conditions. The practice had achieved high results for its QOF indicators and had a policy to rarely exempt patients. In addition to monitoring patients on its QOF registers the practice had developed a range of searches that were regularly run to target

Good

Are services effective?

(for example, treatment is effective)

conditions and patients that were not included under the QOF. These were undertaken on average every three months and included patients taking a range of medicines or with a condition that were omitted. For example;

- Patients on a blood thinning medicine who had not received a blood test in the last three months.
- Patients taking thyroid medicine who had not received a recent monitoring blood test.
- Patients taking disease monitoring anti-rheumatic medicines (DMARDS) without an appropriate monitoring blood test.
- Patients with elevated blood glucose levels, who were not recorded as having diabetes or pre-diabetes.
- Patients who were on the practice prostate register.
- Patients who were on more than 30 days supply of an opioid pain medicine per issue.

These searches gave the practice an oversight of patients who might otherwise not be reviewed by the usual QOF and practice registers to ensure they received appropriate care and treatment. There were systems in place to ensure patients were contacted if they fail to return following abnormal test results.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 43 patient CQC comment cards we received were very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We spoke with eight patients and three members of the patient participation group (PPG) on the day of our inspection. They all told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded with kindness and compassion when they needed help and provided support when required.

Results from the national GP patient survey showed patients were extremely satisfied with how they were treated and that this was with compassion, dignity and respect. Results from the most recent Friends and Family test, showed 95% of those who responded would recommend the practice, this was from 22 responses. The practice was well above average for all its satisfaction scores on consultations with doctors and nurses. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 98% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%
- 97% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 96% patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Each GP ran a personal list, we were told this significantly improved the quality of care they were able to provide and enabled the GPs to build up long-term relationships with their patients. GPs and nurses liaised closely with each other and there was a system of peer support when a GP was absent. Patients were able to choose to see other GPs should they prefer. GPs and nurses undertook opportunistic health screening and chronic disease management including administering flu vaccinations. When patients were registered at the practice they were given the opportunity to change to another GP of choice, for example should they prefer to see a female or male GP. Each GP summarised their patients' medical records when they registered and we were told this was to ensure the GP could develop a clear understanding and knowledge of their patients' medical history. This also gave the practice the opportunity to ensure the information they held for their patients and their families was correct.

Patients we spoke with told us that health issues were discussed with them, they often saw their own GP, their health needs were known by clinicians and they were involved in making decision about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also extremely positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded extremely positively to questions about their involvement in planning and making decisions about their care and treatment and results were in well above local and national averages. For example:

Are services caring?

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 94% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice also had a number of services available within the practice. Examples of these included midwifery services, an in-house health trainer and the specialist diabetic nurse.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers. Support offered to them included referral for Social Services and written information for carers to ensure they understood the various avenues of support available to them.

Through speaking with staff, patients and other health providers, such as the specialist diabetic nurse and the manager of a care homes we found there was very strong focus on the care of patients within the practice. Patient care was an overriding factor in all management decisions and the practice utilised every opportunity to improve the service they offered for the patients who used them. The inspection team was impressed at the way the practice had an overriding view of how they could improve access and outcomes for their patient population, with a focus on those in their community with limited access to health services. For example, one GP provided individual support to patients in their own homes for transfusion services and provided a member of the homeless patient population with a point of contact when required.

In addition the practice was aware of a high incidence of mental health and alcohol and drug dependence problems in the community. The practice undertook health checks on all its patients with a diagnosis of mental health and wrote to those who did not attend for review to ensure as many as possible benefited from this support. We saw that 95% of patients on the mental health register had received health checks in the previous twelve months. Searches were run on patients prescribed medicines to treat depression and the practice liaised with the Mental Health Trust to ensure they were being monitored. Having lost their local Mental Health worker due to a national lack of resources, the practice liaised with the Mental Health Trust and had recently secured the services of two local liaison workers. We were told the local liaison workers were a new initiative and the practice would continue to monitor the service provided to its patients.

Patient and carer support to cope emotionally with care and treatment

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Written information was provided to help carers and patients to access support services. This included organisations for poor mental health and advocacy services. Subject to a patient's agreement a carer could receive information and discuss issues with staff.

From minutes of the practice's multi-disciplinary meetings we saw that the clinicians were proactive in supporting population groups such as families, children and young people, older patients, patients experiencing poor mental health and patients at risk of isolation to receive both practical and emotional support when needed. This was particularly important given the practice was located in central Great Yarmouth with a major problem with very high teenage pregnancy and termination of pregnancy rates and high levels of deprivation with a significant number of children on the child protection register. In addition the practice had a high incidence of mental illness and alcohol and drug dependence were common in the area.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG and other health organisations to plan services and to improve outcomes for patients in the area. For example, the practice together with the local physiotherapy department offered patients a physiotherapy service. This was a scheme where a patient at the practice could contact a qualified physiotherapist directly without a referral from their GP. An initial assessment was undertaken over the telephone and where appropriate advice and/or appropriate exercise advice was given.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- The practice offered 'Early Worker' pre bookable appointments on Tuesday and Thursday mornings between 7am and 8am for patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice reviewed patient admissions data monthly. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. We saw that the practice had a tracking system in place which ensured patients' referrals were actioned.
- The practice worked with the local learning disabilities team to ensure patients on its learning disability register had been correctly identified and received the correct support.
- A diabetic nurse facilitator was available at the practice.
- There were disabled facilities, hearing loop and translation services available.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative care patients. Meetings were minuted and audited and data was referred to the local CCG.
- The practice worked closely with the medicines management team towards a prescribing incentive scheme (a scheme to support practices in the safe reduction of prescribing costs).
- Online appointment booking, prescription ordering and access to basic medical records was available for patients.
- The practice quarterly newsletter was available on-line.
- Chlamydia test kits were available at the practice.
- Emergency contraception was available at the practice.
- In response to the high rates of teenage pregnancy and termination of pregnancy (TOP) rates in the area, one GP had trained to fit intrauterine coil devices and implants. Largely as a result of this the number of patients undergoing TOPs had steadily dropped from 45 in 2011 to 16 in 2014.The practice continued to promote this service.
- The practice worked closely with community midwives, mental health link workers, substance abuse and alcohol support workers and diabetic specialist nurses and promoted provision of these services from the surgery premises where possible. For example local midwives provided clinics at the practice three times per week.
- The practice manager liaised monthly with local health visitors to check the list of 'at risk' patients and to ensure the health visitors were aware of children who had not attended for childhood immunisations and children who had been included on the child protection register or who were vulnerable to abuse.
- A health trainer was available at the practice to support weight management, alcohol reduction and smoking cessation and could refer patients to a local gym as part of a local exercise referral scheme for further support and guidance.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am every morning to 11am and from 2.30pm to 5pm, we were told if the appointments were full the surgeries were extended to ensure all patients could see their own GP on the same day. Pre-bookable extended hours surgeries were offered

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Tuesday and Thursday mornings between 7am and 8am for patients who could not attend during normal opening hours. In addition to pre-bookable appointments that could be booked from three to six months in advance, urgent appointments were also available for people that needed them.

GPs ran personal lists and saw their patients and families. However patients were able to see a GP of choice when available, for example patients could choose to see a GP of their preferred gender. Practice nurses did not run specific chronic disease clinics, but provided patients with appointments for these reviews when they needed them. This also applied to appointments for cervical smears and immunisations. These meant patients were able to access the appointments they required when they needed them. There were phlebotomy appointments each morning from Monday to Friday and we were told the practice often booked patients in following their appointment with the GP. These were recently extended to include afternoon appointments.

The practice maintained a turnaround of repeat prescriptions within 24 hours. GPs undertook pro-active weekly 'ward rounds' at two local care homes. Home visits were available for patients who required them, we were told the practice took a great deal of pride in the provision of care they offered patients in the end of life and had recently had the highest planned death rate at home within the local CCG. The practice worked closely with the palliative care team and actively encouraged and helped patients to remain at home should they wish to in their last weeks and days. The palliative care team meetings helped ensure this happened. One GP described the systems the practice put in place for patients on end of life to ensure they were supported through their end of life wishes.

Results from the national GP patient survey showed that patient's' satisfaction with how they could access care and treatment was well above local and national averages and people we spoke with on the day were able to get appointments when they needed them. For example:

- 95% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 98% patients said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 93% patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 92% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a dedicated GP partner with responsibility for complaints and a deputy (should a complaint involve the GP lead).

The policy explained how patients could make a complaint and included the timescales for their acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. We looked at complaints recorded in the last 12 months and saw that these had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice. We saw the practice aimed to resolve any complaints swiftly and effectively and learn from what happened. As a result most were dealt with at the verbal stage. The practice manager recorded all of these for review. We were told there had been so few written complaints that the practice recently changed its policy to ensure that all verbal complaints and comments were recorded as well. All were discussed; actions agreed and fed back to patients and the practice team. The practice manager told us they tried to do this in as open and honest a way as possible.

A summary of each complaint included, details of the investigation, the person responsible for the investigation,

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

whether or not the complaint was upheld, and the actions and responses made. We saw that complaints had all been thoroughly investigated and the patient had been communicated with throughout the process.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for its patients. This included a mission statement 'to give high quality, cost effective, organised, personal, responsive medical care (but still to enjoy coming to work and have a decent work/life balance).'

The practice values were driven by the management team and embraced by all practice staff we spoke with. These included the provision of a traditional model of general practice in a well organised service. The GPs ran personal lists and believed that continuity of care and long term relationships between the patient and their GP improved quality of care and was fundamental to patient satisfaction. We were told the practice aimed to see patients on the day rather than send patients away to re-book an appointment. Feedback from staff, patients and the meeting minutes we reviewed showed regular engagement took place to ensure all parties knew and understood the vision and values.

A five year business plan was in place and this included a supporting action plan demonstrating a commitment to continuous learning and development. For example, succession and professional development plans for the GPs and practice manager. The practice involvement in training medical students and GP registrar training had not only secured development and recruitment of new GPs and GP partners at the practice, but had been constructive in securing GP recruitement to other practices in the area.

There was an on-going drive to deliver integrated care and enhance services for patients. For example, in response to the high rates of teenage pregnancy and termination of pregnancy (TOP) rates in the area, the practice fitted intrauterine coil devices and implants. The practice had seen a 60% decrease in the number of patients undergoing TOPs since 2011. The practice continued to promote this service. In addition the practice worked with the local physiotherapy department to provide patients a direct physiotherapy service. This scheme enabled patients the opportunity to refer directly to a qualified physiotherapist without a referral from their GP.

There was a clear understanding of the challenges facing the practice and the locality, and staff were keen to improve outcomes for patients. This included established strong links with the community and external stakeholders and a focus on disease prevention by promoting healthy living and empowering patients to participate in their health management.

Governance arrangements

The practice had systems in place to drive improvement and monitor the quality of care and the services it offered. There was an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure, staff were aware of their roles and responsibilities. This included designated lead roles for staff to ensure accountability. Staff we spoke with felt valued and supported by the GPs and management team and described an open culture throughout the practice.
- There was a comprehensive range of practice policies to ensure the safe and effective running of the practice. There was a schedule in place to ensure policies were regularly reviewed or reviewed when required. The schedule ensured policies were up to date and where appropriate in line with relative guidance. Staff had access to policies and were trained to ensure the policies were implemented appropriately.
- There was a comprehensive understanding of the practice performance. The practice used a range of information which included peer review, performance data, feedback on quality, information and feedback from staff and patients to continually monitor its performance and assess areas for improvement. There was a programme of continuous clinical and internal audit to monitor quality and to make improvements to ensure patients received safe care and treatment. The practice held weekly educational meetings where audits, NICE guidelines, prescribing updates, recent deaths, new cancer diagnoses and acknowledged errors and mistakes were discussed. The practice took part in regular training events organised by the CCG (4 per year) for the locality. In addition the partners met for coffee after morning surgery on a near daily basis.
- The practice had completed reviews of incidents, compliments and complaints. Records showed that regular clinical and non-clinical meetings and audits were carried out as part of their quality improvement

Are services well-led?

Outstanding ☆

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

process to improve the service and patient care. Completed 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. Where audits had taken place, these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.

- There were robust arrangements for identifying, recording and managing risks. Action plans were in place to address improvement in areas identified. For example the practice was aware and had strategies in place to manage the monthly increase in its patient population, estimating approximately 50 patients per month who, due to a reduction in services in the area were registering with the practice.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged an open culture of sharing knowledge, regular discussion and mutual support.

Staff told us that regular team meetings were held and that there was an open culture within the practice. Staff described how they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners and the practice manager at the practice.

We saw from the minutes of team meetings that all staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Every member of staff we spoke with were positive and enthusiastic about working in the practice. Visiting health professionals described the effective and open communications they had with the practice team.

The GPs outlined an ethos of good communication between the team even during surgeries and described it as the 'glue that held the team together'. The daily morning clinical coffee breaks provided clinicians with the opportunity for discussion and reflection with their peers and colleagues; we were told clinicians would often telephone each other for clarification or insight during consultations.

The practice was committed to teaching medical students from the University of East Anglia Medical School and training GP registrars. These are fully qualified doctors who were gaining further experience in general practice. We spoke with one GP registrar during our inspection who described the induction process undertaken when working at the practice. This included all areas from a tour of the building, practice policies, procedures and safeguarding to lunchtime tutorials with the lead GP trainer, tutorials on computer systems such as choose and book (a computer referral system) and training meetings. In addition we were told of the total educational and pastoral support from the first day at the practice and the involvement of all the partners in supporting and encouraging training and supervision.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient Representation group (PRG) and through surveys, complaints received and the Friends and Family test, the 'Big Listen' (a feedback service organised by the local CCG) and personal contact with patients and local health care providers.

The practice had a virtual PRG consisting of 15 members, (this is a group of patients registered with the practice who have an interest in the service provided by the practice and who liaise with the practice through emails, letters and face to face) and had made efforts to engage with the various population groups representative of the practice patient population. For example the practice had a large population from Europe and had recruited patient representatives to the PRG from this group. The practice continued to encourage younger patients to become involved with the PRG by invitation to new patients, on the practice website and through the practice newsletter.

Following the 2014/2015 PRG survey the practice worked with the PRG and had put in place a three point action plan. Actions included;

Are services well-led?

Outstanding ☆

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

- Improvements to the downstairs waiting area.
- Improvements to the appointment system, the practice continued to sustain a high proportion of 'did not attend appointments' and worked with the PRG to inform and educate patients as to the loss of clinical time and resources. The practice published information and statistics through the practice newsletter and on the website.
- Improvements to telephone access.

This also outlined progress made in the previous year from the 2013/2014 survey, including the work undertaken by the practice to recruit to the PRG which had proved successful. These actions were approved and signed off by the PRG.

The practice produced a quarterly patient newsletter, to keep patients informed about the practice and to give them information about health promotion and prevention of ill health. For example, a local non-profit making support organisation had recently attended the practice during the flu campaign to promote the 'message in the bottle' scheme. This was a scheme for anyone living at home that ensured vital information was available to identify them and to give advice of their medication and recent illness for the emergency services.

The practice had also gathered feedback from staff through staff away days and general staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. We saw notes of staff meetings and there was a clear focus on the patient experience and improving the service provided. All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. We saw evidence of staff training needs analysis to ensure all staff training requirements were addressed. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice worked closely with a local care home to review care plans and improve polypharmacy and was in the process of meeting with the management team of a second home to review the same.

The practice developed a range of searches and guidance for staff in the management of patients not included in QOF. Examples of these included the care and review of patients with a high blood glucose level who had not been diagnosed with diabetes.

The practice provided support to patients to remain in their own home, for example one GP provided weekly phlebotomy support to vulnerable patients where local district health services were unable to provide support. The practice also provided support for homeless patients who had no other point of reference.

The practice was a long standing teaching and training practice. The local GP training scheme had been set up by two previous partners and as a result of training the practice had been able to recruit GP partners from the scheme. We saw that with the exception of one partner, all the partners had come to the practice through the local scheme. In addition several ex-trainees from the practice were recruited to other local GP surgeries. Three partners were GP trainers and one GP an associate trainer. One partner was the programme director for the Broadland GP speciality training programme. One partner was responsible at the practice for training medical students from the University of East Anglia and one partner was the unplanned care lead for the local Clinical Commissioning Group (CCG) and was the appointed medical advisor for the local CCG Health executive.

The practice looked to improve the staff skill mix within the practice, for example one receptionist had recently trained as a phlebotomist. In addition the practice encouraged work experience and teaching attachments from a local college and had recruited staff as a result of this.