Thorpewood Medical Group

Quality Report

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Date of inspection visit: 14th July 2015
Date of publication: 07/01/2016

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?	Outstanding ☆
Are services caring?	Good ●
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 conducted a comprehensive announced inspection on 14th July 2015.

The overall rating for this practice is outstanding.

We found that the practice was outstanding in relation to being effective, well led and responsive to patients' needs. They provided a safe, effective, caring, responsive and well led service.

They were outstanding for being well led, effective and responsive in providing services for people living in vulnerable circumstances. They were outstanding for well led and responsive to families, children and young people. The practice was outstanding in their effectiveness and responsiveness in providing services to older people and they were outstanding in their effectiveness for people with long term conditions. They were good for working age people (including those recently retired and students), and people experiencing poor mental health (including people with dementia).

Our key findings 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, addressed and shared with staff during meetings.
- Risks to patients and staff were assessed and managed. There were risk management plans which included areas such as premises, medicines handling and administration, infection control and safeguarding vulnerable adults and children.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles. Staff were supervised and supported and any further training needs had been identified and planned for.
- Patients were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. They told us that access to appointments with GPs and nurses was good and that they were happy with the treatments they had received.

Summary of findings

- Information about services and how to complain was readily available and easy to understand. Complaints were handled and responded to in line with relevant guidelines.
- 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 sought feedback from staff and patients, which it acted on.

We saw a number of areas of outstanding practice.

- The practice had written two policies which the local Clinical Commissioning Group (CCG) had adopted and distributed to the other Norfolk practices. These were a transgender policy, which was a response to an identified need within the practice and local CCG and an adoption policy created from working with National Adoption Advisors. They had identified the need for the policy within their CCG and were currently using both.
- The GPs worked closely with drug dependence teams to support vulnerable patients such as those with a drug and alcohol addiction or those with poor mental health. They received referrals from and made referrals to the Norfolk Recovery Partnership which was a Norfolk wide initiative. The practice independently built a relationship with the East Coast Recovery service to forge a stronger and wider impact to assist vulnerable patients. They worked closely with the Norwich Admiral Nurse for dementia care. Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia.
- The practice organised external disability awareness and visual awareness training and changes were made to the way the practice accommodated these patients. For example, help was offered to patients with check-in and registration and a lower area of the reception desk was installed after consultation with patients about the design so that staff could greet patients with mobility problems at their level.
- The practice had a specialist prescribing nurse who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours' referrals and clinics at the care homes that were supported by the practice. The work of the specialist nurse had cut the risk of a repeat admission by over half to the statistical expectation.

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 providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. When incidents occurred these were investigated to help minimise reoccurrences. 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. Patients including children who were identified as being at risk were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe.

Premises were clean and risks of infection were assessed and managed. There were health and

Safety and infection prevention and control policies in place. The practice had suitable equipment to diagnose and treat patients, and medicines were stored and handled safely.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Data showed patient outcomes were in line with the average for the locality and where there were areas for improvement the practice was proactive in dealing with these. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) which was used routinely to improve care and treatment outcomes for patients. Patients' needs were assessed and care was planned and delivered in line with current legislation. Clinical audit cycles were used to monitor treatments and clinical procedures which resulted in improved outcomes for patients.

The practice had a specialist prescribing nurse who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours' referrals and clinics at the care homes that were supported by the practice. The work of the specialist nurse had cut the risk of a repeat admission by over half to the statistical expectation.

Patients' general health was monitored through health screening checks and patients with long-term medical conditions were reviewed annually to assess and monitor their conditions and

Summary of findings

ensure that the treatment they received was appropriate. The practice provided a range of health promotion advice and sessions including smoking cessation clinics and advice on healthy diet and lifestyle choices.

Staff had received training appropriate to their roles and further training provided by the practice encouraged patient awareness. The practice organised additional training outside of required learning that would benefit both staff and patient care. This comprised of disability awareness and visual awareness training and changes were made to the way the practice accommodated these patients. For example, help was offered to patients with check-in and registration and a lower area of the reception desk was installed after consultation with patients about the design so that staff could greet patients with mobility problems at their level. Where further training needs had been identified, it was planned to meet these needs. Staff were supervised and their performance was appraised each year. Staff worked with multidisciplinary teams to ensure that patients received effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice higher than others for several aspects of care such as patients had confidence and trust in the GPs they saw and that they were good at explaining tests and treatments. These were higher than the Clinical Commissioning Group and national average. Patients we spoke with on the day of the inspection confirmed this commenting that the GPs and nurses took time to ensure that they understood treatments and procedures. They trusted their care to them and that they were happy with the practice and had confidence in the staff.

Information to help patients understand the services available was accessible, multicultural and easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received positive remarks from the patients we spoke with during the inspection.

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 the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had adapted its appointments system to meet the needs of working age patients by offering early morning appointments and also appointments later in the day. Saturday

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morning appointments were available. They offered online booking for appointments for ease. Urgent appointments were available each week day. The practice considered the facilities and made adjustments to meet the needs of patients with mobility difficulties. The practice was well equipped to treat patients and meet their needs.

The practice had a specialist prescribing nurse who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours' referrals and clinics at the care homes that were supported by the practice. The work of the specialist nurse had cut the risk of a repeat admission by over half to the statistical expectation.

The practice had developed a transgender policy which had been authorised by the CCG to be adopted by other Norfolk practices and they had worked with National Adoption Advisors on an adoption policy which the practice was using and had been approved by the CCG to be distributed wider to other Norfolk practices.

The GPs worked closely with drug dependence teams to support vulnerable patients such as those with a drug and alcohol addiction or those with poor mental health. They received referrals from and made referrals to the Norfolk Recovery Partnership and East Coast Recovery treatment and recovery services. They worked closely with the Norwich Admiral nurse for dementia care. Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia.

The practice worked closely with a local refuge and patients could be registered and seen on the same day.

Additional staff training from outside sources was supplied by the practice. This comprised of disability awareness and visual awareness training.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. The ethos within the practice was to provide high quality patient centred care and treatment within a friendly and caring environment and that the patients' well-being was their concern. Staff demonstrated this in the care and treatment provided to patients. They had a clear vision and strategy and staff knew their responsibilities in relation to this.

There was a robust leadership structure and staff told us they felt supported by management. Staff said that the practice management was open and approachable. There was a practice

charter, which outlined how staff would treat patients and how patients were asked to treat staff. The practice had a vision and staff were aware of their responsibilities in relation to this. Staff were clear of their roles and areas of responsibility and were empowered to make decisions independently. There was a clear managerial and clinical leadership structure for support. This enabled risk to be escalated promptly if needed and action taken following decisions made.

The practice had a number of policies and procedures to govern its activity. These were all in date and a date identified for their review. There were systems in place to monitor and improve quality and identify risk.

The practice had written two policies which the local Clinical Commissioning Group (CCG) had adopted and distributed to the other Norfolk practices. These were a transgender policy, which was a response to an identified need within the practice and local CCG and an adoption policy created from working with National Adoption Advisors. They had identified the need for the policy within their CCG and were currently using both.

Staff received an induction, regular performance reviews, appraisals and attended staff meetings. All the staff we spoke with reported that they had appropriate training, opportunities to gain additional qualifications and felt very well supported in their work. Staff had attended clinical and peer support meetings.

The practice sought feedback from patients via the NHS Friends and Family Test. The practice had a Patient Reference Group (PRG) which met three times a year. A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PRG told us how they were consulted on decisions regarding practice changes and improvements.

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 

This practice is rated as outstanding for the care of older people. They are rated outstanding in their effectiveness and responsiveness to patient care. Patients over the age of 75 years had a named accountable GP who was responsible for their care and treatment. The GPs carried out visits to patient's homes if they were unable to travel to the practice for appointments. The practice provided a range of health checks for patients aged 75 years and over.

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and then the information was recorded on their patient record. Carers were provided with information and support to access local services and benefits designed to assist them.

Seasonal flu vaccination and shingles vaccination programmes were provided. The practice used a holistic care approach for all patients aged over 75, where clinicians assessed their health and social care needs.

Nationally reported data showed that outcomes for patients were in line with the national statistics for conditions commonly found in older patients.

The practice worked closely with other health care professionals and agencies such as the district nursing team, health visitors and palliative care nurses. There was a specialist prescribing nurse who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours referrals and clinics at the care homes that were supported by the practice. The expertise and time dedicated solely to these vulnerable patients ensured that there was consistent care and access to the right treatments and home visits when needed.

Regular clinical meetings were held for staff to share knowledge and discuss care. The GP Patient survey results scored the practice highly in regards to patient care and all older patients we spoke with on the day of the inspection said that the care and treatment was excellent.

Summary of findings

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions. They are rated outstanding for their effectiveness in patient care. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual reviews of their health.

Regular medication reviews were undertaken to ensure that their treatment remained effective.

Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions. Data from the Quality and Outcomes Framework (QOF) for diabetes showed the practice scored higher than the national average for the correct management of the condition.

The practice had developed a specialist prescribing nurse role who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours referrals and clinics at the care homes that are supported by the practice. The expertise and time dedicated solely to these vulnerable patients ensured that there was consistent care and access to the right treatments. This gave the GPs more time to deal with other patients. The specialist nurse, nursing team and GPs worked together to provide cohesive care for the patients with long term condition with structured annual reviews in place to check that the health and medication needs of patients were being met. Patients told us they were seen regularly to help them manage their long term health and always felt involved in their care and treatment.

When needed, longer appointments and home visits were available. 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.

Families, children and young people

Outstanding

The practice is rated as outstanding for the population group of families, children and young people. They are outstanding in their responsiveness to patient care and for being well led. Appointments could be booked in person by telephone or online. The premises were suitable for children and young babies with a separate play area in the waiting room. Appointments were made available outside of school hours wherever possible. Children under five years of age were always seen by a GP when making an urgent appointment.

Information and advice was available to promote health to women before, during and after pregnancy. The practice monitored the physical and developmental progress of babies and young children.

Summary of findings

The practice provided sexual health support, testing and treatment. They offered contraception, maternity services and childhood immunisations with appropriate clinical staff. There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them, as well as other checks for new-born babies. The practice held a fortnightly immunisation clinic.

There were arrangements for identifying and monitoring children who were at risk of abuse or neglect. Records showed that looked after children (such as children in foster care / under the care of the Local Authority) those subject to child protection orders and children living in disadvantaged circumstances were discussed in practice clinical meetings and multidisciplinary meetings. Any issues were shared and followed up at monthly multidisciplinary meetings. All practice staff were trained to recognise and respond to acutely ill babies and children and to take appropriate action.

The practice had written an adoption policy from working with National Adoption Advisors. The practice was currently using it and the Clinical Commissioning Group (CCG) had adopted it and distributed it for use at the other Norfolk practices.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments could be booked online, in person, by telephone and could be booked in advance. The practice had appointments available on a Saturday morning for convenience as well as from 8am to 6.30pm week days.

The practice provided travel advice and vaccinations through appointments with the practice nurse team. Information on the various vaccinations was available on the practice website.

When patients required referral to specialist services they were offered a choice of services, locations and dates. These referrals were made in a timely way and monitored to ensure that patients received the treatments they needed.

People whose circumstances may make them vulnerable

Outstanding

This practice is rated as outstanding for the care of people living in vulnerable circumstances. They are outstanding for their effectiveness and responsiveness to patient care, and for being well led. The practice had a register of patients who had learning

disabilities. All patients with learning disabilities were invited to attend for an annual health check. Patients who did not attend their health check were sent a text message reminding them that they had missed the appointment and inviting them to re-book. They would also receive a telephone call and if they missed multiple appointments then the practice would write to the patient.

The practice had written a transgender policy, which was a response to an identified need within the practice and the local CCG had adopted and distributed it to the other Norfolk practices.

The GPs worked closely with drug dependence teams to support vulnerable patients such as those with a drug and alcohol addiction or those with poor mental health. They received referrals from and made referrals to the Norfolk Recovery Partnership which was a Norfolk wide initiative. The practice independently built a relationship with the East Coast Recovery service to forge a stronger and wider impact to assist vulnerable patients.

The practice regularly worked with multidisciplinary teams in the case management of vulnerable patients. 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. The practice had a specialist prescribing nurse who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours referrals and clinics at the care homes that are supported by the practice. The expertise and time dedicated solely to these vulnerable patients ensured that there was consistent care and consistent access to the right treatments. GPs who signed up to the direct enhanced service (DES) would need to identify the 2% most vulnerable patients using an appropriate risk stratification tool. The work of the specialist nurse had cut the risk of a repeat admission by over half to the statistical expectation. Their 2% vulnerable patients (223 at date of inspection) that were under the admission avoidance scheme (admitted by out of hours), were rung by the specialist nurse for assessment. This was within 48 hours of discharge and he organised any further treatment, visited them himself or arranged the GP to visit. The total number of home visits provided by the specialist nurse saving GPs from having to leave the surgery was 682 from 1st January 2014 to 1st June 2015. During the same period a total of 3190 telephone consultations were made by the specialist nurse to direct the most effective and appropriate care for the patients. Care plans are also organised by him. This gave the GPs more time to deal with other patients.

Additional staff training from outside sources was supplied by the practice. This comprised of Disability Awareness and Visual

Summary of findings

Awareness training. Changes were made to the way the practice accommodated these patients, for example, help was offered to patients with check-in and registration and staff stood at the new lower area of the reception desk to greet patients with mobility problems.

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 patients with dementia). The practice worked closely with the Norwich Admiral Nurse for dementia care. Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia.

Patients with dementia and memory problems were routinely tested under the directed enhanced service as part of a dementia assessment. Support was offered to the patients, families and carers and double length appointments with the clinicians were booked.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Patients felt their experiences with the practice were positive. They told us that they were treated with dignity and respect and the GPs, nurses and all other staff were kind, supportive and helpful. They said they did not feel rushed during appointments and that they had all details of their care explained to them which made them feel included in their own care.

Data available from the National GP Patient survey published in July 2015, showed that the overall practice scores were similar to the national average. The majority of patients reported higher than average satisfaction with the practice GPs. They had confidence and trust in the practice GPs which scored 98% which had a 95% national average and they were in line with the national average of 85% for GPs being good at treating them with care and concern. 92% said they were good at explaining tests and treatments to them which had a national average of 86% but the practice had low scores on getting an appointment with a preferred GP in a timely manner at 27% with a national average of 60% and 38% found it easy to get through by telephone to the practice which was a national average of 73%. After patient feedback, the practice had recently changed the telephone system to improve the service for patients. Recent Friends and Family test results showed that between 73% and 91% of patients who responded in 2015 up to the date of inspection in July 2015, would recommend the practice to other people based on the quality of the care they received.

Outstanding practice

We saw several areas of outstanding practice which included

- The practice had written two policies which the local Clinical Commissioning Group (CCG) had adopted and distributed to the other Norfolk practices. These were a transgender policy, which was a response to an identified need within the practice and local CCG and an adoption policy created from working with National Adoption Advisors. They had identified the need for the policy within their CCG and were currently using both.
- The GPs worked closely with drug dependence teams to support vulnerable patients such as those with a drug and alcohol addiction or those with poor mental health. They received referrals from and made referrals to the Norfolk Recovery Partnership which was a Norfolk wide initiative. The practice independently built a relationship with the East Coast Recovery service to forge a stronger and wider impact to assist vulnerable patients. They worked closely with the Norwich Admiral Nurse for dementia care. Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia.
- The practice organised external disability awareness and visual awareness training and changes were made to the way the practice accommodated these patients. For example, help was offered to patients with check-in and registration and a lower area of the reception desk was installed after consultation with patients about the design so that staff could greet patients with mobility problems at their level.
- The practice had a specialist prescribing nurse who was dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours' referrals and clinics at the care homes that were supported by the practice. The work of the specialist nurse had cut the risk of a repeat admission by over half to the statistical expectation.

Thorpewood Medical Group

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 lead CQC Inspector, a GP specialist advisor and a Practice Manager specialist advisor.

Background to Thorpewood Medical Group

Thorpewood Surgery is situated in Thorpe St Andrew which is a small town and suburb of Norwich in Norfolk. The practice has six GPs, five male and one female, nine members of nursing staff, three health care assistants, one phlebotomist, one midwife, eighteen administration staff and four managers supporting 14100 patients registered with them.

The practice is managed by five GP partners, a practice manager, a business manager, a patient services manager and an IT manager.

The practice is open from 8am to 6.30pm Monday to Friday and 8am to 11.30am on Saturdays. Urgent appointments are available on the day. Routine appointments can be pre-booked in advance in person, by telephone or online. Telephone consultations and home visits are available daily as required.

The Out of Hours care for patients is provided by theNHS 111 service outside the normal practice opening hours (6.30pm to 8am, weekends and bank holidays).

The other provider of an out of hours service is the Walk in Centre Service, Norwich Practices Health Centre, Norwich, open 9am to 7pm daily.

Why we carried out this inspection

We inspected Thorpewood Surgery as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

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

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

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:

Detailed findings

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

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 14 July 2015.

During our inspection we spoke with the GP partners, the salaried GP, the practice manager, the patient services manager, three practice nurses and two reception/admin staff. We spoke with five patients who used the service and two patients from the Patient Reference Group (PRG) and viewed documents and records relating to the management of the practice.

Good

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. Reported incidents and National Patient Safety Alerts were used as well as comments and complaints received from patients to collate risk information. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed 12 months of safety records, incident reports and minutes from meetings where these issues were discussed. This showed that the practice had managed risk and patient safety consistently over time and could show evidence of a safe track record.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. We saw minutes of practice meetings, communicated emails to staff and discussions with the staff, that information was shared so as to improve patient safety. Staff told us that managers communicated with them regularly.

Learning and improvement from safety incidents

Complaints, accidents and other incidents such as significant events were reviewed regularly and discussed at practice meetings to monitor the practice's safety record. A root cause analysis (which is a method of problem solving used to identify the causes of issues or problems) was carried out to determine where improvements could be made and to identify learning opportunities to prevent reoccurrences and to take action to improve on this where appropriate. Staff we spoke with could give examples of learning or changes to practices as a result of complaints or incidents reviewed. For example, one significant event related to checks not being undertaken in relation to repeat prescriptions being handed to patients. This was discussed at a practice meeting and learning and change occurred after this event.

Staff we spoke with told us that the practice had a no blame culture and said that there was an open and transparent culture for dealing with incidents or near misses. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved.

Reliable safety systems and processes including safeguarding

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

There was a system to highlight vulnerable patients on the practice's electronic records. This included information of any relevant issues when patients attended or failed to attend appointments; for example looked after children or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed at fortnightly clinical meetings and monthly multidisciplinary team meetings, which were attended by health visitors, district nurses and Macmillan nurses. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed, followed up, and appropriate referrals were made as required.

A chaperone policy was in place (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The chaperone policy described the clinicians' responsibilities for determining when a chaperone would be needed. We saw that where patients were identified as requiring a chaperone that this was recorded within the electronic patient records system so that staff were alerted when the patient visited the practice.

Chaperone duties were undertaken by nursing and administration staff. The practice manager, staff and evidence of training confirmed that the appropriate staff

had undertaken the required chaperone training. From records viewed we saw that criminal records checks had been carried out with the Disclosure and Barring Service (DBS) for all staff working as chaperones at the practice. Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. Patients we spoke with were aware that they could request a chaperone during their consultation if they chose to.

Patient's individual records were kept on the practice electronic system which collated all communications about the patient and with the patient including scanned copies of communications from hospitals. We saw evidence that staff were able to use it to record and store information around patient safety and safeguarding vulnerable patients.

Medicines Management

Medicines were managed safely so that risks to patients were minimised. Medicines were documented, checked and stored correctly. There was secure storage of medicines, including vaccines, emergency medicines and medical oxygen. We saw documents showing that medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines and these were found to be in the correct quantities from the log of medicines and in date. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The practice nurses also administered medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses had received appropriate training and had been assessed as competent to administer the medicines referred to either under a PGD or in accordance witha PSD from the prescriber.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had robust arrangements for reviewing patients with long term conditions to ensure that the medicines they were prescribed were appropriate and that risks were identified and managed. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Staff told us that patients who were prescribed medicines on a longer-term basis were monitored and were contacted to attend regular medication reviews. They told us that letters and text message reminders were sent and follow up calls made as needed.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed form and via the practice website. Patients could order repeat prescriptions in person at the practice, by post or online through the secure clinical electronic system (for patients who were registered for online access). 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.

There was a system in place for the management of high risk medicines such as medicines used in the treatment of terminal and life limiting illnesses, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. No controlled drugs were kept at the practice.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients and staff against the risks of infections. Hand sanitising gels were available for staff use however there were none available for patient use on entering the practice. Hand washing sinks with liquid soap, hand gel and paper towel dispensers were available in treatment rooms. The clinical rooms had disposable curtains which were dated to when they were hung. The rooms were clean and not cluttered. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had in place infection control policies and procedures for staff to follow, which enabled them to plan and implement measures for the control of infection. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. All clinical staff had undertaken

infection control training and staff underwent screening for Hepatitis B vaccination and immunity. Staff who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. All staff were provided with appropriate personal protective equipment including gloves and aprons. Spill kits were available to manage any spillage of bodily fluids.

The practice employed three agency cleaning staff for its general cleaning. We saw there were cleaning schedules in place for the general and clinical areas and that these were documented. The practice nurses told us that they were responsible for cleaning the treatment room in between patient consultations. Nursing staff and the practice manager told us that regular visual checks were carried out on the premises and equipment to ensure that they were clean.

Records we viewed showed that infection control audits had been carried out to test the effectiveness of the general cleaning and infection control procedures within the practice. These audits demonstrated that the practice had systems in place for identifying and managing risks of infections.

The practice did not have a policy for the management, testing and investigation of legionella (water borne bacteria found in the environment which can contaminate water systems in buildings). However we saw that the practice had completed a risk assessment where the highlighted risks were documented and actions were taken to ensure safety.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment including blood pressure monitoring devices, scales and thermometers were periodically checked and calibrated to ensure accurate results for patients.

We saw records showing that other equipment required for the safe running of the practice, including fire detecting (smoke detectors) and firefighting equipment were visually checked weekly. Full service checks and replacements, as required, were carried out by an external company. The fire alert which consisted of specialist fog horns to alert staff and members of the public to the event of a fire were tested six monthly. The practice had a schedule for testing the portable electrical equipment and this had been carried out. Portable appliance testing (PAT) is an examination of electrical appliances and equipment to ensure that they are safe to use.

Staffing & Recruitment

The practice had procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. The practice recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff, including identity checks, qualifications and professional registration with the appropriate professional body. We saw evidence that all staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) or General Medical Council (GMC). We looked at the records for five staff members to check that the practice was compliant with their own recruitment policy. We saw evidence that appropriate recruitment checks had been undertaken. Employment references and criminal records checks through the Disclosure and Barring Service (DBS) were in place for each of the members of staff. There were procedures in place for managing any disciplinary issues.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. Staff worked extra days if required and locum GPs were sourced when necessary. At the time of our inspection there were six GPs with a practice patient list of 14,100 patients. GPs and the managers told us that they worked to ensure that they provided a flexible and safe service to patients. Staffing levels were regularly reviewed to ensure there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place to ensure that locum GPs were sourced, if required, to deal with any changes in demand to the service as a result of both unforeseen and expected situations such as seasonal variations (winter pressures or adverse weather conditions).

Monitoring Safety & Responding to Risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included accident reporting, checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

We saw that a log of incidents, complaints and significant events had been kept at the practice and they had all been

appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they were aware of these procedures. Staff were able to demonstrate the correct action to take if they recognised risks to patients; for example they described how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health issues or crisis. We saw that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing all staff had received training in basic life support. Emergency medicines and oxygen was available at a dedicated place within the practice as were anaphylaxis medications (containing medicines to treat severe allergic reaction). Oxygen warning signs were visible and algorithm charts were attached to the area to ensure the correct treatment was given during the emergency situation. All staff asked knew the location of these medicines. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date, documented and fit for use.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, water failure, adverse weather, epidemic/pandemic, unplanned sickness, accident or terrorism and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken signposting the practice as low risk. It included actions required to maintain fire safety. We saw that the fire safety and evacuation procedure was displayed throughout the practice. Fire alert tests and fire drills were conducted six monthly using fog horns and not a conventional alarm. Smoke detectors were situated throughout the practice. Staff we spoke with were aware of the procedures to follow in the event of a fire or other untoward event which would require the building to be evacuated.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice GPs and nurses carried out reviews for patients with long term conditions. The GPs and nursing staff we spoke with could clearly 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) and from local commissioners. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient has fair access to quality treatment. We saw that NICE guidelines were available to all clinicians. Information and new guidance were made available and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments.

We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Records we saw showed us that the practice's performance in assessing and treating patients with long term conditions such as asthma and chronic respiratory illnesses, were in line with the local Clinical Commissioning Group (CCG) averages.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We saw no evidence of discrimination when making care and treatment decisions. Discussions with GPs showed that the culture in the practice was that patients were referred on need, and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice had a robust system for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. It was clear from minuted meetings that the audits were discussed and responsive plans were initiated and acted upon. The practice had recently audited anticoagulant medicines (commonly known as blood thinning medicines) where they had identified the patients taking the medications, checked whether the patients were taking them short term or long term and a review date for the medication was set. This audit was discussed at a practice meeting where it was compared to the same audit from the previous year ensuring a fully completed audit cycle. The practice produced evidence of a large number of clinical audits. We looked at 14 which were all fully completed.

We looked at the data and information we held about the practice. This included information taken from the Quality and Outcomes Framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions for example diabetes or mental health and implementing preventative measures. The QOF data from 2013/2014 showed that the practice scored above the local Clinical Commissioning group (CCG) and England average in many of the clinical indicator groups. The practice achieved an overall total score of 94% of the points available. Since the date of Inspection, more recent QOF data had been published for 2014/2015 and the practice scored 100% of the total points available. This was 3.6% above the CCG average and 5.5% above the England average.

The practice kept a register of patients who were receiving palliative care and treatment. They were monitoring and planning care in line with the needs of these patients. The practice held regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The practice has a specialist prescribing nurse and their role had helped cut the risk of a repeat admission by over half to the statistical expectation (69.77% down to 28.25%). Their 2% vulnerable patients (223 at date of inspection) that were under the admission avoidance scheme (admitted by out of hours), were rung by the specialist nurse for assessment. This was within 48 hours of discharge and he organised any further treatment, visited them himself or arranged the GP to visit. The total number of home visits provided by the specialist nurse saving GPs from out of surgery time was 682 from 1st January 2014 to 1st June 2015. During the same period a total of 3190 telephone consultations were made by the specialist nurse to direct the most effective and

appropriate care for the patients. Care plans are also organised by him. This gave the GPs more time to deal with other patients. This ensured that continuous personalised care was available for the most vulnerable patients and that the patients knew exactly who would respond to them.

The practice was commissioned for the enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). These were, childhood vaccination and immunisation scheme, extended hours access, facilitating timely diagnosis and support for patients with dementia, influenza and pneumococcal immunisations, minor surgery, encouraging a patient participation group, remote care monitoring and rotavirus and shingles immunisations.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with essential training courses, such as basic life support, fire safety and safeguarding adults and children.

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

The practice nurses were registered with the Nursing and Midwifery Council (NMC). We saw a training log and training certificates in staff files. The nurses we spoke with confirmed their professional development was up to date.

The staff we spoke with confirmed they had received annual appraisals. They told us it was an opportunity to discuss their performance and any appropriate training they either needed or wanted to attend. All the staff we spoke with felt they were well supported in their role and confident in raising issues with the practice manager or GPs. We saw evidence of the induction programme in staff files and the staff described how they had undertaken it and been supported through the first few weeks of settling into the practice and familiarising themselves with relevant policies, procedures and practices. The practice employed staff who were skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for five members of staff. We saw evidence that all staff were appropriately qualified and trained. Staff we spoke with told us that the practice provided opportunities for learning and that they undertook a range of online and face-to-face training. There was additional staff training from outside sources supplied by practice. These comprised of disability awareness and visual awareness which gave a first-hand experience of poor eyesight and mobility problems to the staff to enable understanding of the restrictions a patient with reduced eyesight or mobility problems may encounter.

The practice had dedicated leads for overseeing areas such as safeguarding, dermatology, diabetes and asthma. The practice nurses had undertaken specific training in health promotion such as, smoking cessation, weight problems and sexual health screening and the treatment of minor illness The nurses provided services including new patient medicals, long term condition reviews, family planning and cervical screening.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs, including those with complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test results, X-ray results, letters including hospital discharges, out of hours providers and the NHS 111 summaries were reviewed and actioned.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were to discuss patients with complex needs. These meetings were attended by GPs and other professionals as required, according to the needs of the patients being discussed. Decisions about care planning were documented in a shared care record. We looked at the records for the last five meetings and found that detailed information was recorded, reviewed and shared to ensure that patients received coordinated care, treatment and support.

Information Sharing

The practice used electronic systems to record and store patient data. Staff used an electronic patient record to co-ordinate, document and manage patients' care. The

computer systems were protected by smart cards and passwords. All staff were fully trained on the system. This system enabled scanned paper communications, such as those from the hospital, to be saved in the system for future reference. Electronic systems were in place for making referrals and, in consultation with the patients; these could be done through the Choose and Book system. (The Choose and Book system is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)

There was a system for making sure test results and other important communications about patients were dealt with. These were passed to GPs to review and act on as required.

The practice maintained registers for patients with life limiting illnesses, those identified as vulnerable or frail and patients with mental health conditions or those with learning disabilities. GPs and nurses at the practice worked closely with palliative care nurses and other agencies which supported patients with life limiting illnesses. They held a monthly palliative care and multidisciplinary meetings to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs. Other health and social care professionals attended to help ensure that patients received coordinated care and treatments as needed.

Staff were alert to the importance of patient confidentiality and the practice had appropriate policies and procedures in place for handling and sharing patient information.

Consent to care and treatment

We found the clinicians were aware of the Mental Capacity Act 2005 and Children Acts 1989 and 2004 and were able to describe how they implemented it in their practice. Clinicians demonstrated an understanding of legal requirements when treating children. They 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. The Mental Capacity Act is designed to protect patients who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in their best interests.

The practice had policies and procedures in place for obtaining patient consent for care and treatment. The procedures included information about a patient's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients verbal or written consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children. The nurse we spoke with told us that they obtained parental consent before administering child immunisations and vaccines.

Health Promotion & Prevention

There was a wide range of information leaflets about health promotion and healthy lifestyle choices available within the waiting rooms where patients could see and access them. We saw information about mental health, domestic violence advice and support that was prominently displayed in waiting areas with helpline numbers and service details. There was information and guidance available on diet, smoking cessation and alcohol consumption. There was information available about the local and national help, support and advice services. This written information was available in English and various other languages and some leaflets were available in braille.

The practice offered Nordic walking classes under a "Healthy Norwich" initiative. The practice said they recognised the benefits of walking to some of their patients' health care and they secured funding for it.

They worked with the parish nursing project which helps local churches appoint nurses, who in turn support people and communities towards whole person healthcare. They promote care for the person's overall well-being, incorporating body, mind and spirit.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. Nurse led clinics and pre-bookable appointments were available including sexual health, family planning, coronary heart disease prevention, diabetic and asthma clinics. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Information about the range of

Outstanding ☆

Are services effective?

(for example, treatment is effective)

immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Childhood immunisation clinics were run daily. Childhood immunisation rates from the practice for the vaccinations given to under two year olds ranged from 74.1% to 98.8%. Five year olds receiving vaccinations ranged from 91.6% to 100% which were both comparable to the CCG and National averages.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the information available from the National GP Patient survey published in July 2015. Two hundred and fifty five surveys were sent out and one hundred and nine were returned which is a 43% completion rate. We saw that 98% had confidence and trust in the last GP they saw or spoke with which was higher than the local Clinical Commissioning Group (CCG) average of 96% and the national average of 95%. A further 92% said the last GP they saw or spoke with was good at explaining tests and treatments which was higher than the CCG and national average of 86%. Patients we spoke with at the practice said they could see a preferred GP but would have to wait a few days longer but understood that they could see a GP quickly when urgently required. They felt they were treated with diginity and respect, listened to and not rushed during appointments.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. During the inspection we spent time in the reception area. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients.

There was information on the website and in reception explaining that patients could request a chaperone during examinations. Patients we spoke with told us that they knew they could have a chaperone during their consultation should they wish to do so. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that GPs and nurses were very good. They spent time explaining information in relation to their health and the treatments in a way that they could understand. Some patients said that the length of time to wait for a specific preferred GP appointment was longer than they felt acceptable and this was consistent with the result published in the July 2015 National GP Patient survey. 27% of patients reported they were usually able to see or speak with a preferred GP, as opposed to an average of 61% in their CCG and 60% nationally. Data regarding care and treatment showed, 85% of patients said the last GP they saw or spoke with was good at treating them with care and concern which was in line with the local (CCG) and national average of 85%. The practice monitored the Friends and Family test results and received a good percentage of patients that would recommend the practice to other people based on the quality of the care they received.

The practice had an electronic appointment check-in system, which was set up to reflect the most common languages used in the area. Staff had access to an interpretation and translation service via telephone. Information was available on the website, from reception and displayed in the waiting room. Patients we spoke with were aware that translation services were available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection highlighted that staff responded compassionately when they needed help and provided support when required.

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration. Carers were provided with information and support to access local services and benefits designed to assist them.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Staff told us that families who had suffered bereavement were called by the GP.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice outstanding for their response to patients' needs. They had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and family planning. These were led by Clinical Commissioning Group (CCG) targets for the local area, and the practice engaged regularly with the CCG to discuss local needs and priorities.

The practice had good access with no stairs or steps and three large waiting rooms. All clinical rooms had wide door frames and large rooms with space for wheelchairs and prams/pushchairs to manoeuvre.

The appointment system was effective for the various population groups that attended the practice. The working age population registered at the practice were able to obtain appointments on weekdays at 8am until 6.30pm. Saturday morning appointments were available between 8am and 11.30am. Longer appointments were available for patients with learning disabilities, those with poor mental health and those with long-term conditions or complex needs. Home visits were available for those with limited mobility or otherwise unable to get to the practice.

There were 12 languages available on the electronic book-in system, information leaflets available in other formats including Braille, the website could translatable into 90 languages, a language translation service was available, and a hearing loop for patients hard of hearing was also available. The practice had a very low number of patients registered who did not speak English well but they had developed assisted communications in an effort to make the system future proof should the number of patients increase significantly who required the service.

The GPs worked closely with drug dependence teams and local chemists to support vulnerable patients such as those with a drug and alcohol addiction or those with poor mental health. They received referrals from and made referrals to the Norfolk Recovery Partnership and East Coast Recovery treatment and recovery services. They worked closely with the Norwich Admiral nurse for dementia care. Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia.

The practice worked closely with a local refuge and patients could be registered and seen on the same day.

Data from Public Health England showed that the practice had a higher than average amount of patients with long term conditions, health related problems in daily life, nursing home patients and patients with caring responsibilities. The practice responded by establishing a new role dedicated to primarily cater for that demographic of patients called a specialist prescribing nurse. They were dedicated to palliative care, at risk patients, elderly dependant patients, housebound patients, out of hours referrals and clinics at the care homes that were supported by the practice. The expertise and time dedicated solely to these vulnerable patients ensured that there was consistent care and consistent access to the right treatments. GPs who signed up to the direct enhanced service (DES - an enhanced level of provision above what is required under a core general medical service contract) would need to identify the 2% most vulnerable patients using an appropriate risk stratification tool. The work of the specialist nurse had cut the risk of a repeat admission by over half to the statistical expectation (69.77% down to 28.25%). Their 2% vulnerable patients (223 at date of inspection) that were under the admission avoidance scheme (admitted by out of hours), were rung by the specialist nurse for assessment. This was within 48 hours of discharge and he organised any further treatment, visited them himself or arranged the GP to visit. The total number of home visits provided by the specialist nurse saving GPs from out of surgery time was 682 from 1st January 2014 to 1st June 2015. During the same period a total of 3190 telephone consultations were made by the specialist nurse to direct the most effective and appropriate care for the patients. Care plans are also organised by him. This gave the GPs more time to deal with other patients. This ensured that continuous personalised care was available for the most vulnerable patients and that the patients knew exactly who would respond to them. The nurse had been a district nurse prior to the current role and was experienced in seeing patients out in the community and the feedback that the practice received regarding this specialist nurse and the benefit to patients was overwhelmingly positive. The practice had received multiple compliments from their

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

patients and relatives on the care, advice and treatment the nurse had given. Additionally the practice had a nurse who specialised in lung conditions and a recently appointed nurse who specialised in Diabetes both with extensive histories of working within those fields prior to joining the practice.

The practice had identified the need for a transgender policy within the practice and the local CCG and had written a policy which was taken up by the CCG. It was distributed to other practices in the Norfolk area to use. An adoption policy had been written and was being used by the practice and had been authorised by the CCG to be distributed further to other Norfolk practices. The basic principles were to prevent the child from being traced by the birth family and important medical information from the pre-adoptive record was summarised into post adoptive record. They also wanted to ensure pre and post adoptive paper records were kept separate whilst ensuring both records transferred together when the patient changed surgery. The proactive drafting of these policies, demonstrated that the practices' ethos of an inclusive approach to the well-being of all of the patients within the practice and its wider area was evidenced and patients across Norfolk would benefit from them.

Tackling inequity and promoting equality

The practice had registers of patients who may be living in vulnerable circumstances and those with learning difficulties, and staff were able to give examples of how these helped them deal sensitively with patients, for instance offering extra support to attend or longer appointments.

The premises and services met the needs of patients with disabilities. The entrance was accessible to prams/ pushchairs and wheelchairs and allowed for easy access to the treatment and consultation rooms. The corridors and waiting rooms were clear and more than adequately sized.

Some information leaflets in reception/waiting room were available in braille.

Accessible toilet facilities were available for all patients attending the practice including baby changing facilities and the practice was breast feeding friendly.

The practice staff had been given additional external training on disability awareness and visual awareness which all staff reported as helpful in order to meet the needs of patients and understand various difficulties and restrictions the patients had to overcome daily. The trainers used training aids to give practical demonstrations of reduced vision and mobility which ensured the staff got first-hand knowledge of difficulties patients faced when attending the practice. The practice used this knowledge to improve access for those patients. Help was then offered to patients with check-in and registration and a lower area of the reception desk was installed after consultation with patients and the practices Patient Reference Group (PRG) about the design so that staff could greet patients with mobility problems at their level.

Access to the service

Patients could make appointments by telephone, calling at the practice, or online. Repeat prescriptions could be ordered online. The practice was open from 8am to 6.30pm Monday to Friday and from 8am to 11.30am on Saturdays. Urgent appointments were available on the same day. Routine appointments could be pre-booked in advance in person, by telephone or online. Home visits were available daily as required.

The National GP Patient survey published in July 2015 showed that 38% reported they found it easy to get through to the practice by telephone with the average both nationally and within the CCG being 73%. The practice had recently changed telephone systems following complaints and from discussions with the PRG and this data from the survey, the practice had responded to the feedback by making changes. The practice monitored the Friends and family test results and a good percentage of patients would recommend the practice to other people based on the quality of the care they received.

The facilities and premises were suitable for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. The practice also used a social media site to keep their patients updated on practice information.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for patients who needed them and those with long-term conditions.

We gathered the views of patients from the practice by speaking with five patients and two representatives from the patient reference group (PRG). The response from patients was vastly positive with patients reporting that staff at the practice were helpful, kind, polite and supportive. The only less positive issue expressed was appointment availability for a preferred GP. Patients we spoke with at the practice said they could see a preferred GP but would have to wait longer but understood that they could see a GP quickly when urgently required.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. The practice manager handled written complaints, but all staff were aware of the complaints procedure and would in the first instance attempt to deal with complaints when they occurred. The practice kept records of complaints received and discussed them in practice meetings. Audits were carried out regularly and re-audited to confirm that learning had taken place from them. Information on how to complain was contained in the patient leaflet, on the practice website, and was displayed in reception. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received and found they were satisfactorily handled and dealt with in a timely way.

We looked at a summary of complaints and could see that these had been responded to in a timely manner, and a full investigation undertaken. The patient was then contacted with a full explanation and where necessary an apology.

The practice summarised and discussed complaints at practice meetings, or where necessary on a one to one basis with staff members or as part of their appraisal. The practice was able to demonstrate learning and changes as a result of complaints, such as rewriting of practice information, re-training a member of staff or changing the telephone system when patients complained. We saw minutes of meetings where shared learning and action points were discussed.

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 and strategy to deliver high quality care and promote good outcomes for patients in an open and friendly environment. Staff we spoke with were aware of the vision and values for the practice and told us that they were supported to deliver these. The practice was active in focusing on outcomes in primary care.

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear and accessible to staff and reviewed regularly. Staff told us that they were aware of their roles and responsibilities within the team. Some members of staff had lead roles; these included palliative care, infection control and safeguarding. There was an atmosphere of teamwork, support and open communication.

The practice had a robust system for completing clinical audit cycles. The practice had fully completed audit cycles to review and monitor outcomes for patients and it was clear from minuted meetings that the issues were discussed and responsive plans were initiated and acted upon.

There were policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working in the practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance.

From a review of records including minutes from staff meetings, appraisals, complaints and significant event recording, we saw that information was regularly reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments.

Leadership, openness and transparency

All staff we spoke with told us that GPs and the practice management team were approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held monthly meetings and met more frequently where required to discuss any issues or changes within the practice.

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

The practice sought feedback from patients on a regular basis through the NHS Friends and Family Test. They were actively seeking feedback from their patient reference group (PRG). They had regular meetings three times a year with the PRG to discuss planned changes and gain opinions on matters that concern the patients and practice. The purpose of the PRG is to ensure that the patient voice was represented. The activities of the group were to look after the patients by drawing attention to strengths and weaknesses in the provision of health care in the area. Their aim was to help the practice by providing patient feedback, to the medical and non-medical staff attached to the surgery, about the level and quality of services they offer. The telephone system was recently changed due to patient and PRG feedback to the practice and the practice had received complaints regarding the access to the telephone service. This had showed in their scoring of the National GP patient survey published July 2015 (data collected from the previous year). Friends and family test results for the year of 2015 to the date of inspection in July, ranged from 73% to 91% of patients who responded, would recommend the practice to other people based on the quality of the care they received. The practice monitored feedback on the NHS Choices website and replied to patients positive or negative comments quickly, with advice and action plans and where appropriate an apology.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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 in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff and the staff we spoke with said that they would feel confident in reporting any concerns.

Are services well-led?

Outstanding ☆

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

Management lead through learning & improvement

The practice had management systems in place 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. Staff told us that the practice consistently strived to learn and to improve patient experience and to deliver high quality patient care. The practice organised additional training outside of required learning that would benefit both staff and patient care. This comprised of disability awareness and visual awareness training and changes were made to the way the practice accommodated these patients. For example, help was offered to patients with check-in and registration and a lower area of the reception desk was installed after consultation with patients about the design so that staff could greet patients with mobility problems at their level.

The practice had identified the need for a transgender policy within the practice and the local CCG and had written a policy which was taken up by the CCG. It was distributed to other practices in the Norfolk area to use. An adoption policy had been written and was being used by the practice and had been authorised by the CCG to be distributed further to other Norfolk practices. The basic principles were to prevent the child from being traced by the birth family and important medical information from the pre-adoptive record was summarised into post adoptive record. They also wanted to ensure pre and post adoptive paper records were kept separate whilst ensuring both records transferred together when the patient changed surgery. The proactive drafting of these policies, demonstrated that the practices' ethos of an inclusive approach to the well-being of all of the patients within the practice and its wider area was evidenced and patients across Norfolk would benefit from them.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan.