Dr Bouch and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Bouch and Partners on 28 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive services, and for being well led. It was also good for providing services for all the population groups.

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, reviewed and addressed.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The GPs, nurses and healthcare team at the practice had knowledge and skills which enabled the practice to offer a wide range of services to patients. It employed advanced nurse practitioners who were able to see a broader range of patients than the practice nurse and had led to an increase in the number of appointments available to patients.
- Information about services and how to complain was available and easy to understand and patients' complaints were responded to empathetically.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

Summary of findings

We saw several areas of outstanding practice including:

- There was a strong learning culture and the practice was committed to primary care development and education. It took an active part in GP education and primary care research and encouraged staff at all levels to develop their knowledge and skills.
- The practice had developed an audit programme which was both comprehensive and embedded. The practice had completed an extensive scheme of clinical audit cycles, covering a broad range of areas. There was evidence that this had led to improvements in outcomes for patients. We saw that the results of audits had been shared routinely across clinical teams.
- The practice proactively engaged with local voluntary groups. The Citizen's Advice Bureau (CAB) attended the practice every month, and the practice hosted carers' support days every three months with good attendance rates by patients. Local community groups such as Age UK, and patient advice and liaison services regularly gave talks at the staff meetings to raise their awareness of services that could be accessed by patients.

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

Importantly the provider should

- Have a system in place to monitor the non-collection of prescriptions.
- Ensure that chaperone services are better advertised to patients.
- Hold review meetings about vulnerable patients with safeguarding concerns with other health and social care professionals

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. Lessons were learned and communicated widely to support improvement. The practice had suitable equipment to diagnose patients, and medicines were managed safely. Recruitment procedures were robust and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently positive. Information for patients about the services available was easy to understand and accessible. The practice actively supported unpaid and informal carers to help them maintain their role.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice had made changes to the appointment system based on feedback from patients and a period of research. The new system had been well received. There was a clear complaints system with evidence demonstrating that the practice responded to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service. Managers of local care homes confirmed that the patients living in their homes received responsive and effective care from the practice's staff.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and supported well by the practice. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. It had built up effective relationships with the care homes it provided services to.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff were experienced and well trained in chronic disease management, and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were easily available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. There was an efficient and effective recall system in place. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Acupuncture was provided to those with chronic musculoskeletal conditions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify children living in disadvantaged circumstances and who were at risk. Immunisation rates were good for all standard childhood immunisations and the practice offered a weekly walk in vaccination clinic. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice offered a wide range of family planning advice and treatment to all age groups. There was a chlamydia screening service for 15-24 year olds.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances might make them vulnerable. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability. However only 60% of patients with learning disabilities had received an annual health check, and none had been given a health action plan, outlining how their health care needs would be met.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 63% of people experiencing poor mental health, and 89% of those living with dementia had received an annual physical health check. People with mental health problems were invited to attend a combined appointment to see the nurse initially, and then a 30 minute appointment with a GP to review their physical and mental health. A large number of staff had attended a dementia awareness training session provided by the local Alzheimer's association. Further training was planned to increase staff's awareness of mental health.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection and also received 10 completed comment cards. Overall patients felt supported and described the practice's staff as helpful, efficient and empathetic to their health concerns. Patients reported that getting through to the surgery on the phone was easy, as was booking an appointment at a time that suited them.

Patients told us they did not usually have to wait a long time once they had arrived for their appointment, and did not feel rushed during their consultation. Patients also reported a good experience with getting repeat prescriptions.

These views aligned with the results of national GP survey which had been completed by 129 patients. Patients consistently rated the practice higher for access and quality of care provided by clinicians. Overall the practice had achieved a score of 92%, making it one of the best performing GP practices.

Care home managers spoke very positively about the responsiveness of the service and the caring nature of GPs who visited their homes. Two reported that the end of life care offered to their residents from the GPs was excellent.

Areas for improvement

Action the service SHOULD take to improve

- Have a system in place to monitor the non-collection of prescriptions.
- Ensure that chaperone services are better advertised to patients.
- Hold review meetings about vulnerable patients with safeguarding concerns with other health and social care professionals.

Outstanding practice

- There was a strong learning culture and the practice was committed to primary care development and education. It took an active part in GP education and primary care research and encouraged staff at all levels to develop their knowledge and skills.
- The practice had developed an audit programme which was both comprehensive and embedded. The practice had completed an extensive scheme of clinical audit cycles, covering a broad range of areas. There was evidence that this had led to improvements in outcomes for patients. We saw that the results of audits had been shared routinely across clinical teams.
- The practice proactively engaged with local voluntary groups. The Citizen's Advice Bureau (CAB) attended the practice every month, and the practice hosted carers' support days every three months with good attendance rates by patients. Local community groups such as Age UK, and patient advice and liaison services regularly gave talks at the staff meetings to raise their awareness of services that could be accessed by patients.

Dr Bouch 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 and practice manager specialist advisor.

Background to Dr Bouch and Partners

Dr Bouch and Partners is a well-established GP practice that has operated in Lowestoft for over 40 years. It is a member of the Great Yarmouth and Waveney Clinical Commissioning Group and serves 10,500 patients. The practice has a Primary Medical Services (PMS) contract with NHS England.

According to information taken from Public Health England the patient population has a higher than average number of patients aged 55-85 years, and a lower than average number of patients 0-44 years compared to the practice average across England. There is a high prevalence of hypertension, depression, heart disease, respiratory disease, asthma and stroke amongst its patient population compared to the national average. It has the highest number of patients in residential and nursing homes in north Lowestoft and Lound.

The practice is a partnership of six GPs who hold managerial and financial responsibility for the practice. The partners employ one salaried GP, two nurse practitioners, five nurses and one assistant nurse practitioner. They are supported by a range of administrative and reception staff.

The practice is open between 8.30 am and 6.30 pm Monday to Friday. Telephone lines are open from 8 am. The practice is also open on Saturday mornings between 8am and 11 am. The out of hours service is provided by IC24, a not for profit social enterprise company.

Why we carried out this inspection

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?

Detailed findings

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 July 2015 During our visit we spoke with a range of staff including the practice manager, GPs, nurses and a range of administration and reception staff. We also spoke with patients who used the service and the chair of the practice's patients' participation group. We 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

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed a number of significant events from the previous year to our inspection and saw that staff had raised concerns on a range of issues including patient administrative errors, a missed home visit and unsheathed needles not disposed of correctly.

We reviewed safety records, incident reports and minutes of meetings for the previous six months to our visit which showed that incidents and significant events were discussed in detail. An overview of all written complaints received within the previous year had been reviewed at the practice's clinical governance meetings of 16 June 2015.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of five significant events that had occurred during the last year and saw this system was followed appropriately. The reports contained good information about what had happened, why it had a happened and what had been learnt from them.

Significant events were regularly shared at the appropriate practice meeting. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. For example, minutes of the nurses' meeting held on 6 January showed that a recent incident in a baby clinic whereby an immunisation was given too early had been discussed. Minutes of the administration/reception staff meeting on 16 June 2015 showed that a significant event which resulted in a home visit being missed had been reviewed, as well as the action to prevent its reoccurrence.

The practice manager informed us that a specific monthly significance events meeting was about to be introduced to ensure that all events were properly monitored and analysed.

National patient safety alerts were disseminated by the practice's nurse manager who emailed them to all relevant clinicians. Clinicians emailed back to state what action would be taken in response. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had a children and young people safeguarding policy and an adult safeguarding policy. These were based on national and local guidance and were tailored to the needs of the practice.

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies. Staff gave us specific examples of safeguarding incidents they had come across in their work and the action they had taken to protect patients. In one instance this had involved sheltering a patient at the practice until the safeguarding team could remove them to a place of safety. Contact details of relevant safeguarding organisations were easily accessible in each treatment room and in a yellow folder in the reception office.

The practice had appointed a GP as the lead in safeguarding vulnerable adults and children. All staff we spoke with were aware who this lead was and who to speak with in the practice if they had a safeguarding concern. We spoke with the safeguarding lead who demonstrated they had the necessary competency and training to enable them to fulfil these roles. They reported they were to undertake further training in safeguarding 16 and 17 year olds in November 2015. They had recently attended a safeguarding leads training provided by the CCG and showed us a presentation they had put together following the training to share with colleagues at the practice. This included a specific case study around the issue of female genital mutilation (FGM) and the legislation requiring GPs to report cases of it. The lead had identified areas where

the practice could improve its safeguarding procedures and had plans in place to develop a FGM protocol, improve the recording of who accompanied children to appointments and to audit the reasons children did not attend appointments. However, the practice did not regularly attend meetings with other health and social care professionals to discuss vulnerable patients with safeguarding concerns.

We saw that staff had been asked to read the practice's PREVENT policy (a government policy aimed at stopping people becoming terrorists or supporting terrorism) people at the meeting of June 2015 to ensure they understood its implications.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We reviewed the records of seven children on the child protection register and found all had been flagged on the practice's computer system.

The practice had a chaperone policy and information about requesting a chaperone was available for patients in the waiting area. (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). However the practice's policy stated that there should be a suitable sign offering chaperone services in each consulting or treatment room, but we did not see evidence of this. All nursing and most reception staff had been trained to be a chaperone. Reception staff acted as a chaperone if nursing staff were not available. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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). We were informed that a record that a chaperone had been present, and who they were, was always included in patients' notes.

Medicines management

The practice had comprehensive policies and procedures relevant to the safe management of medicines and prescribing practice.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Records showed that fridge temperature checks were carried out to ensure medication was stored at the appropriate temperature. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were kept securely in a locked metal cupboard and there was a robust system in place to prevent fraud and their misuse. We found that there was no system in place to monitor the non-collection of prescriptions by patients. Staff told us that any uncollected prescriptions would be destroyed after a period of six months.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. A specific staff member was allocated to check patients on these medicines received their blood tests. They ran a search each month, and any patients who had not attended for a blood test were contacted directly by their GP.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place procedures that set out how they were managed. Controlled drugs were stored securely and access to them was restricted to the GPs and the nurse manager only. We checked a small sample of controlled drugs and found they were properly recorded and accounted for.

One of the practice's GPs was the prescribing lead and regularly attended quarterly meetings with the clinical commissioning group (CCG) to discuss medicines' management. Information provided by the practice showed that they regularly analysed and reviewed their

prescribing habits, and also followed prompts from the prescribing team at the CCG. The practice had introduced regular meetings to discuss medicines prescribing and feedback from the CCG's prescribing leads' meeting.

Cleanliness and infection control

The practice had suitable infection control polices and procedures in place which covered a wide range of areas including hand hygiene, vaccine storage and handling specimens. Training records we viewed showed that all staff had received training in infection control.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting areas, corridors and treatment rooms. The patient toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We noted hand hygiene stations through out the practice on corridor walls and in the entranceway. We checked two treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and sealed work surfaces so they could be cleaned easily. There were prompter posters above each sink reminding staff of the correct way to wash their hands. We saw that sharps boxes had been assembled correctly and were not overfull. However they were not wall mounted to ensure their safety.

The practice conducted its own infection control audits. These were comprehensive and covered, amongst other things, the cleanliness of walls, sockets, ceilings, radiators and external glazing. Cleaning schedules were detailed and outlined cleaning frequencies and responsibilities. An independent infection control audit had been completed and the practice had scored 91%.

Infection control was raised regularly at staff meetings and we noted at the nurses' meeting of 6 January 2015 the most effective way to clean carpet tiles after wet contamination spillage was discussed.

We viewed waste notes that showed the practice dealt appropriately with clinical waste.

The practice had completed a risk assessment for legionella (a bacterium which can contaminate water systems in buildings) and we saw records that confirmed the practice was carrying out regular checks to reduce the risk of infection to staff and patients.

The practice had clear policies and procedures in place for the protection of clinical staff against the Hepatitis B virus and personnel files we checked showed that all staff had been immunised appropriately.

Equipment

Staff told us the practice was well equipped and all requests for new equipment were considered and investigated. We saw evidence of this at the clinical governance meeting on 16 June 2015 where the need for new respiratory, nasal injury and weighing equipment had been identified. One nurse told us that their recent request for a stool so that nurses could sit comfortably whilst doing lower leg dressings had been met.

All equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the next testing date was due on 1 July 2016. A schedule of testing was in place. We saw evidence of the calibration and service of relevant equipment; for example weighing scales, spirometers, pulse oximeter and nebulisers.

The practice employed a maintenance officer who was responsible for repairing and maintaining some equipment. We viewed his maintenance book which showed that requests for maintenance work and repairs had been completed

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These 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).

We spoke with one newly recruited member of staff. They reported that they had attended two interviews and had also had to submit three references. They confirmed they had received a full induction to their role which they had found useful.

Good

Are services safe?

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including clinical and administrative staff, to cover each other's annual leave.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had coped well in response to significant staff challenges recently, with the GPs and nurses undertaking additional shifts to cover staff absences.

Monitoring safety and 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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Identified risks were included on a risk log. Risks associated with staffing changes, the effect of a new housing development in Oulton and the introduction of a new computer system had all been identified and their impact carefully assessed. We saw that the register had been regularly updated to ensure the risks were managed effectively.

Doors within the building were secured by keypads to ensure security and safety.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment including access to oxygen and an automated external defibrillator (used in cardiac emergencies) was available in both buildings where patients attended. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator which were within their expiry date.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Each risk had been assessed and rated and mitigating actions recorded to reduce and manage them. Risks identified included power failure, loss of the telephone systems, pandemics, fire and flood. The plan also contained relevant contact details for staff to refer to. The plan was last reviewed in April 2015. Copies of the plan were available in all three buildings and a number of staff also held copies in their own homes. We saw that the plan had been discussed at the staff meeting of 16 June 2015 to ensure staff were aware of it.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Fire equipment was regularly serviced to ensure its effective operation.

An emergency panic button was available on the practice's computer systems so that clinicians could summon assistance in an emergency. Nurses told us they wore an emergency button around their neck when working after hours to summon help if needed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with the GPs and nurses showed that that they were aware of, and worked to, guidelines from local commissioners and the National Institute for Heath and Care Excellence (NICE) about best practice in care and treatment. NICE guidance and local clinical guidelines were all available on the practice's computer system and the GPs and practice nurses knew where to find them. One nurse told us she regularly accessed NICE guidance on line and that links to the latest guidance were on the chronic disease templates that the practice used. She told us she often printed the guidance off to discuss with the GPs to ensure the treatment she was providing patients was in line with it.

Fortnightly clinical governance meetings were held, attended by the GPs and nurses. We viewed minutes of the meetings since January which showed that a range of issues were discussed including latest NICE guidance, complaints, research proposals and results of audits. For example at the meeting on 10 March 2015, the latest guidance in relation to vaccination requirements for splenectomy patients was discussed. At the meeting of 30 June 2015 a representative of the local medicines management team had attended to talk about the prescribing.

Staff described how they carried out comprehensive patient assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. One of the nurse's gave us a very detailed account of how patients with cardiovascular disease were managed to ensure their health and well-being were maintained.

Management, monitoring and improving outcomes for people

There was a wide range of clinical audits completed at the practice by a variety of staff including the use of specialised baby milks, the management of uncomplicated urinary tract infections and contraceptive implants fitted in the surgery. The practice showed us three clinical audits that had been undertaken in the last three years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Clinical audits were often linked to medicines management information or safety alerts. For example, we saw an audit regarding the prescribing of Nitrofurantoin (a type of antibiotic) undertaken as a result of a warning notice published by the Medicines & Healthcare products Regulatory Agency (MHRA). The GPs carried out medication reviews for patients who were prescribed this medicine and altered their prescribing practice to ensure it aligned with national guidelines. As a result the prescribing rate in 2015 was 68% of that in 2014.

The GPs used a specialist computer programme to support medicine prescribing decisions and prescribing rates were similar to national figures for hypnotics, non-steroid anti-inflammatory drugs, antibacterials and antibiotics.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets. It achieved 90.7 % of the total QOF target in 2014, which was just below the national average of 93.5%. Performance for diabetes, osteoporosis, heart disease and respiratory disease related indicators were better than the national average. The practice was aware of all the areas where performance was not in line with national figures and had taken action to improve its performance in relation to mental health and dementia care indicators. QOF results for 2015 indicated that they had improved their performance with an overall achievement score of 95%. (This data was provided to us by the practice and has yet to be validated).

The practice had identified 177 patients with the most significant care needs who needed support to reduce the risk of unplanned admissions to hospital. The practice provided care plans for those patients and we saw evidence that these were comprehensive. Emergency hospital admission rates for the practice were 14.39 % which were similar to the national average 14.4% The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Good

Are services effective?

(for example, treatment is effective)

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

Effective staffing

Despite significant staffing challenges in the previous year to our visit, the practiced had managed to maintain an effective service to patients. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. A GP buddy system was in place to cover absences and administrative staff had pooled task lists so that if staff were absent, their tasks could be undertaken by someone else. Succession planning was in place to replace staff who were known to be leaving in the coming months.

We found staff to be knowledgeable and experienced for their roles. Training records we viewed showed that clinicians had undertaken a wide range of training including coil fitting, minor injury, cervical screening, wound management, as well as training in a number of long terms conditions. The practice had a very good skill mix which included advanced nurse practitioners who were able to see a broader range of patients than the practice nurses. An acupuncturist was employed to provide services one day a week.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. One nurse described the training she had received as excellent from the moment she had started working at the practice. She had just completed a prescribing course, and had undertaken training in family planning, spirometry and asthma. She told she also attended regular study days to keep her knowledge and skills up to date. The practice was supporting another nurse through a degree course to become a nurse practitioner, and a GP to become a trainer. A member of the reception team told us she had just completed an NVQ level 3 in business administration. The assistant practitioner held a foundation degree in primary care. Clinical staff regularly attended training sessions led by the CCG, and one nurse told she had found a recent session on respiratory disorders useful for her work with patients.

The practice also held regular training and educational sessions where it invited outside speakers to attend. Staff had received recent talks from the Alzheimer's Society, Suffolk Family Carers and also the Citizen's Advice Bureau (CAB). Staff told us they found these sessions useful as it gave them good knowledge about local services that could benefit patients. All staff had received dementia care training and further training on mental health issues was planned. The practice manager told us he had recently commissioned a training package for staff on communication skills, conflict management and complaints handling

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this quickly and effectively.

Working with colleagues and other services

The practice provided GP care to older people living in four local care homes. Representatives from these care home confirmed that the practice worked with them in a supportive and helpful way. They said that the GPs were approachable and that staff at the home could talk to the GPs at any time**.** One care home manager told us GPs were good at explaining what they meant not only to residents, but also to her overseas staff who might not be able to understand some subtleties of language and common jargon used.

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Specific staff had additional responsibilities for summarising and Read coding records, for which they had received training. All staff we spoke with understood their roles and felt the system in place worked well.

GPs met monthly to discuss patients with complex needs. For example, those patients with active care plans in place, those who had had unplanned admissions within the last month and those patients admitted to care homes within the previous month. Multi-disciplinary meetings with other

Good

Are services effective?

(for example, treatment is effective)

health and social care professionals were held every three months to discuss these patients. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate

The practice invited local voluntary groups and organisations regularly to its staff meetings. For example, representatives from Age UK and the Citizen's Advice Bureau (CAB) had attended meetings to discuss their services and how they could benefit the practice's patients. The CAB attended the practice once a month to support patients.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. At the time of our inspection the practice was about to change to another clinical system and was confident that this would enable better management and co-ordination of patients' records and care. Administrative staff we spoke with understood the systems used by the practice and their individual role in making sure these worked smoothly. One of them told us that everyone worked hard to keep the workflow of results and tests up to date and that normally these were dealt with on the day they arrived. The medical secretary followed up all urgent two week referral appointments to ensure they had been received and processed by the hospital.

The practice had implemented Summary Care Record for patients. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Consent to care and treatment

The practice had a policy to support staff in fulfilling the requirements of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for them. We saw that patients' consent issues were regularly discussed at a variety of meetings. For example, minutes of the nurses meeting held on 3 February 2015 showed that the practice's policy on the MCA had been discussed to ensure all nursing staff were aware of its implications. At a clinical governance meeting of 10 June 2015, it was decided to write to all the care homes supported by the practice to get a list of residents who were subject to deprivation of liberty safeguards so that their notes could be updated; and at the administrative meeting of 16 June all attendees were given a paper copy of the MCA 2005 to read.

We found that staff were aware of the Mental Capacity Act 2005, 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. Staff were able to give us specific examples of how they implemented in their work. For example one nurse told us they were uncertain if a patient had the capacity to consent to a minor procedure so she rang the care home and the patient's family, in order to make a best interest decision on their behalf. One of the GPs told us he had completed a mental capacity assessment to ensure that their patient was able to decide whether or not to they wanted to enter a care home.

Care home representatives told us that the practice's GPs were good at involving families in important resuscitation decisions on their residents who could not make those decisions for themselves. Patients at the end of life had written care plans and where appropriately agreed had 'do not attempt resuscitation' information available so that patients would not be resuscitated against their wishes.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. This helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

The practice used written patient consent forms for all minor surgery, the removal of skin tags, warts and ear irrigation. We reviewed records for two patients who had undergone minor surgery and found appropriately completed consent forms attached to their records.

Health promotion and prevention

The practice nurses and assistant practitioner provided appointments for a range of health checks and conditions. These included blood tests, health checks, baby immunisations and health reviews for patients with long term conditions such as diabetes or respiratory problems. The nurses told us they offered weight management guidance to patients in their clinic and often made referrals to slimming world, which were very popular. A health trainer offered smoking cessation sessions at the practice.

Good

Are services effective?

(for example, treatment is effective)

All new patients registering with the practice were offered a health check and follow up letter was sent to those who had not taken up the offer to try and encourage them to attend. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that 9.2 % of patients in this age group took up the offer of the health check.

Information given to us by the practice showed that for the year 1 April 2014 to 31 M arch 2015, 30 of 50 patients with learning disabilities had received an annual health check; 45 of 72 patients with mental health problems had received an annual health check, and 126 of 142 patients with dementia had received a health check.

The practice had an informative website which provided information about a wide range of health and care topics and there leaflets in the waiting rooms, giving patients information on a range of medical conditions.

The practice's performance for the cervical screening programme was 80%, which was similar to the national average of 82 %. We viewed the results of an external audit of practice's cervical screening undertaken by the local trust. This showed that the quality of the smears taken by clinicians was good.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. It also operated a walk-in clinic on a Tuesday morning so that patients didn't have to book in advance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 75.83 %, and at risk groups 53.37%. These were slightly above national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 61% to 100% and five year olds from 92 % to 100%. These were above the national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey of January 2015. This showed that patients were satisfied with how they were treated. For example, data from the national patient survey showed the practice was 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 93 % 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 average of 95 % and national average of 95%

GPs held their own personal patient lists, allowing them to get to know patients well and providing continuity of care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and that their dignity and privacy was respected by staff. They said staff treated them in a way that they liked and they usually saw the GP of their choice.

We also received very positive feedback from the four care home representatives we spoke with. They all praised the way the practice's GPs treated their residents, and specifically the patience they showed with their residents living with dementia.

During our inspection we saw that all consultations and treatments were carried out in the privacy of a consulting room. Window blinds and curtains round couches were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Patients' privacy and confidentiality at the reception area was compromised as conversations between reception staff and patients could be easily overheard, However we noted a poster advising patients to let receptionists know if they wanted to speak confidentially to them. Reception staff we spoke with had a good understanding of the importance of patients' confidentiality and spoke knowledgably about the practical ways they maintained it.

We observed number of interactions between the reception staff and people coming into the

practice. Overall, the quality of interaction was good, with staff showing empathy and respect for people, both on the phone and face to face. Figures from the national GP survey showed that 94% of patients found the receptionists at the practice helpful compared to the CCG average of 81% and national average of 73%.

Care planning and involvement in decisions about care and treatment

The survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 96 % said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and national average of 90%.
- 90 % 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%.

We spoke with the manager of a local care home who knew the practice well. She told us that the GPs actively involved residents in decisions about their care and were also good at listening to, and consulting with, her staff about the best way to manage residents' health needs. Another care home manager stated that the GPs were particularly good at communicating with residents and took time to explain treatment options and diagnoses in a way that they could understand. They stated the GPs also took time to liaise with residents' families.

Good

Are services caring?

The practice had identified 177 of their patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. The practice confirmed that they had developed care plans for all of these patients. We checked the records for three patients with complex needs and found good evidence in the notes that treatment options and their care had been discussed with them. Patients needing care at the end of their lives also had advanced care plans.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 81 %.
- 94% 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%.

Information about local health and social care organisations and sources of support and guidance was available on the practice website and at the practice. This included details of various support groups and organisations for carers and families. Patients who were carers were encouraged to register so that the practice were aware of their role and could direct them to local carers' organisations for practical support and advice. Every three months, specific carers' days were held at the practice run by Suffolk Family Carers. All patients on the practice's carers list were sent a personal invitation to attend.

Staff told us that if families had suffered bereavement, their usual GP contacted them. A letter was sent along with useful information about ways of coping with grief and contact details of bereavement support organisations. When palliative care patients died at home the GPs undertook follow up bereavement visits.

One care home manager described the end of life care provided to residents as absolutely brilliant, stating the GPs worked closely with staff, residents and their families to ensure the resident's last days were comfortable, pain free and dignified

Minutes of the staff meeting held on 28 January 2015 showed that the language used to indicate patients had died had been reviewed and changed so it was more compassionate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. They told us that the practice was supportive of other practices in the locality, for example helping them implement IT systems. The practice manager was actively involved in the CCG and sat on its governing body and clinical executive committee.

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided, despite recent staffing difficulties. The practice offered a good range of services to patients including chronic disease clinics, a walk-in vaccination clinic, well woman clinics, family planning services, chlamydia screening services, acupuncture and minor surgery.

Aspects of the service had been specifically designed to meet the needs of its significant older population, many of whom were housebound. For example, a GP was appointed each morning solely to undertake home visits, and the nurses regularly undertook home visits as part of patients' chronic disease management. The practice also supported four local care homes, and visited each at set times throughout the week.

The practice regularly reviewed its services to better meet patients' needs. For example, it had recently reviewed the types of clinics it offered, with those that were under utilised such as cryotherapy reduced to enable more chronic disease clinics to be introduced.

The practice had recently increased the number of nurse clinics available in response to patient concerns. Additional nurse practitioners had been employed so that the practice could increase the number of nurse clinics and same day appointments that were available to patients. In response to low up take of health checks by people experiencing mental health issues, the practice invited patients to a combined appointment to see the nurse initially, followed immediately by a 20 minute appointment with their usual GP to review their physical and mental health. This has resulted in a much improved uptake of health checks.

Following a serious event concerning a patient with learning disabilities, the practice had introduced a more robust recall system to ensure patients with learning disabilities attended annual health check ups. GPs now proactively contacted patients if they failed to attend having been invited three times in a row. Appointment times for these patients had also been doubled, with both a nurse and a GP conducting their health check to ensure all aspects of their health and well being were assessed. GPs and nurses undertaking these checks had received training on the purpose them, the use of the template used to record them and on giving advice and support to these patients. 60% of patients with learning disabilities had received one of these health checks in 2014-2015.

We spoke with representatives from four care homes who told us that the GPs responded quickly to urgent requests for visits to their residents. We met one patient during out inspection who had brought her two children in for a check up with the nurse. As she was complaining of pain in her side during her children's check up, the nurse arranged for her to see one of the practice's GPs immediately following her children's appointment.

Tackling inequity and promoting equality

Both the main surgery and Atrium had ramps and there were automatic entrance doors to make access easier for patients with mobility difficulties. There were large waiting areas with plenty of space for wheelchairs and prams, and also toys to keep children occupied whilst they waited.

The practice had its own wheelchairs on the premises for patients to use if needed. The nurses and GPs regularly visited patients at home if their health or mobility meant they were unable to attend appointments.

Information about the practice was available in large print and also in audio format making it accessible to a range of patients. Reception staff told us they regularly assisted two patients who could not read and write to complete their prescription request forms.

There were male and female GPs in the practice; therefore patients could choose to see a GP of their preferred gender.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comprehensive information was available to patients about appointments on the practice's website and also in its patient information leaflet. This included surgery times, how to book appointments through the website and how to cancel appointments**.** The surgery was open from 08:00 to 18:30 Monday to Friday. It was also open on Saturdays morning between 8 a.m. and 11 a.m. for pre booked appointments with a GP or nurse. Urgent appointments were available on the day and routine appointments could be pre-booked in advance in person, by telephone or online.

Telephone consultations and home visits were available daily as required. Each afternoon the practice ran a triage surgery for patients requiring an emergency appointment. A GP or nurse practitioner rang patients to discuss their health concerns and if an appointment was needed it would be organised for that afternoon. Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. The practice held joint clinics for chronic disease management to avoid multiple appointments for patients with multiple illnesses.

Home visits were made to four local care homes on a specific day each week, to those residents who needed one. The practice had introduced a new scheme for registering patients outwith its usual catchment area, allowing patients who lived elsewhere but worked in Lowestoft to register there.

The practice was proactive in offering online services. A text service was available to remind patients of their appointment and patients could order their repeat prescriptions in person, by telephone, online or by post. Patients could choose to have their prescription sent to a pharmacy of their choice so they did not need to go to the practice to collect it.

The practice had its own car park and had negotiated additional car parking spaces for patients at a nearby church hall during surgery hours.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and consistently rated the practice well in these areas. For example:

- 90% were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 91% described their experience of making an appointment as good compared to the CCG average of 79 % and national average of 73%.
- 94% said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor or nurse on the same day if they felt their need was urgent although this might not be their GP of choice.

Our inspection took place on 28 July 2015. The next routine appointment with a GP was available 4 August 2015, six days following out visit; with a nurse on 30 July 2015, two days following our visit.

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 with good information available in the waiting area and on the practice's web site. The practice's patient information leaflet gave the name of the person responsible for managing complaints and also the address of NHS England for patients who did not want to contact the practice directly. Reception staff spoke knowledgeably about how to manage complaints and the practice's procedure.

Minutes of meetings we reviewed showed that complaints were regularly discussed the appropriate staff meetings so that learning form them could be shared. The practice also reviewed complaints annually to detect themes or trends. At the clinical governance meeting of 16 June 2015 a review of all written complaints had taken place. Although no specific underlying themes or patterns to the complaints had been identified, some complaints indicated a possible communication problem between the practice's staff and patients. In response to this the practice manager had commissioned specific staff training in this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at four recent complaints received by the practice and found they had been dealt with openly and in a timely way. In one instance the practice manager had sent the complainant detailed information about the use of antibiotics to help them understand why the GP had not prescribed them. In another instance a GP had visited the complainant at home, to discuss the findings of the practice's investigation into their complaint.

The practice regularly responded to patients' comments received on the NHS Choices web site, inviting patients to contact them for further discussion about their concerns.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice team showed a strong commitment to providing patients with a safe, high quality and caring service. The practice leadership team were aware of the importance of forward planning to ensure that the quality of the service they provided could continue to develop. The practice had a three year business plan which clearly set out what the practice hoped to achieve, and its goals in the forthcoming years. It was aware of the changing landscape in primary care services and was a member of the GP Federation Iceni.- a group of more than a 100 GP practices in Norfolk and Suffolk set up to collaborate on service provision.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. The partners had various business responsibilities and regularly met away from the practice to discuss business and planning matters. The practice manager was responsible for the day to day running of the practice and dealt with all non-clinical matters. The practice manager had two members of staff with additional responsibilities towards administration and reception management. The nurse manager had responsibility for managing and supporting the nurses.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's computer systems. We looked at 15 policies and procedures and found that they were up to date and had been reviewed regularly. Staff told us that the practice manager was rigorous in ensuring that staff read the policies. Minutes of staff meetings that we reviewed showed that policies were regularly discussed at them. For example at the nurses meeting of 21 April 2014, the practice's lone worker policy had been discussed; at the meeting of 3 February 2015 its Mental Capacity Act policy had been reviewed.

Communication across the practice was structured around key scheduled meetings. There were fortnightly business meetings, fortnightly clinical governance meetings, monthly nurses' meetings, and quarterly administration staff meetings. Administration meetings were held twice in the same day to ensure that as many staff as possible could attend. These meetings often provided opportunities for shared education and learning, as external speakers and trainers were invited such as representatives from the Alzheimer's Society and Citizen's Advice Bureau. Smaller group meetings were held as necessary. We viewed a sample of minutes from all these meetings which were detailed, well written, and with actions arising from them clearly documented. Staff told us they felt the meetings were useful and were always asked for agenda items. Minutes of meetings were kept and easily accessible to staff.

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. Staff told us they had achieved good QOF results because of their proactive assessment and recall arrangements which ensured patients who needed to be reviewed were seen. We saw that QOF data was discussed at practice meetings and action had been taken to address areas of low performance in relation to mental health and dementia indicators.

The practice also had an on-going programme of clinical and non-clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw that audits had been completed to evaluate the availability of nurse clinic appointment times, and another to assess reception staff hours and shift patterns. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies which were in place to support staff such as parental leave, training and stress at work. The practice had a whistleblowing policy which was available to all staff.

Leadership, openness and transparency

The practice had well organised management arrangements to support the GP partners in the running of the practice. Staff told us the practice was well-led citing effective management, good team working, efficient systems, and access to training as the main reasons**.**

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Minutes of all the meetings we reviewed

Are services well-led?

Good

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

(including staff, clinical, nurse and managerial) showed that information about the practice and any challenges it faced were shared openly with staff, and that staff were actively consulted about changes to the practice.

The practice also regularly shared information with the patient participation group (PPG). Minutes we viewed from the most recent meeting held on 10 June 2015 showed that the PPG had been kept up to date with currents changes in staffing, the rotas and clinics. Results of the National GP survey were also shared with members of the PPG to ensure they were kept up to date with how the practice was performing.

Staff spent time together outside practice hours to help them build and develop their relationships as a team. The partners held away days in which business matters were discussed and there were social events involving the whole practice team, such as summer and Christmas parties. Staff jointly fund raised for charitable causes and held two to three big fundraising events each year.

Seeking and acting on feedback from patients, 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 participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG had identified that there were not enough nurse clinics available for patients. In response to this, the practice increased the number of nurse clinics and extended the times they were available. The PPG had also identified some concerns about a member of staff: as a result this member of staff had been provided with additional training.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Results of these were monitored closely by the practice manager. Patients could also leave any suggestion they had in a box in the practice's main waiting area.

The practice also gathered feedback from staff through team meetings, appraisals and the use of suggestion boxes where staff could leave their suggestions and ideas anonymously either on computer or in a box in the reception office. One GP reported that their concerns about the practice's current IT system had been considered seriously, and a reception staff member told us her suggestion to improve the way care home residents were registered with the practice had been implemented.

Management lead through learning and improvement

There was a strong focus on continuous learning and improvement at all levels within the practice.

We found that the partners were very aware of the value of education and effective skill mix not only for the GPs but also for members of all staff groups within the practice. One of the GPs had nearly completed a training course so that the practice could continue to provide placements for doctors wishing to become GPs. The practice had supported administration staff to achieve NVQ levels 2 and 3, and nursing staff to obtain prescribing qualifications and diplomas for diabetes ad respiratory conditions. At the time of our inspection the practice was supporting one nurse through a degree course to become a nurse practitioner**.**

All the staff we spoke with felt supported by the practice and reported that they were encouraged to develop their knowledge and skills. All staff had protected learning time, where the practice closed for an afternoon to engage in a range of educational and training events led by the CCG. The partners were committed to improving primary healthcare and recognised the value of research, and regularly participated in a range of studies and research initiatives. There was a structured system for providing staff in all roles with annual appraisals of their work and planning their training needs.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.