Dr Castle & Partners, Sole Bay Health Centre

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Good ●
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Castle and Partners also known as Sole Bay Health Centre on 24 November 2015. Overall the practice is rated as outstanding.

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

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

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

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

We saw several areas of outstanding practice including:

Summary of findings

- The Southwold Care Services Improvement Partnership (CSIP) project reflected the complex needs of the older population, with the majority of individuals supported being over 85yrs. The practice was in the process of discussions with the clinical commission group for an adjoining plot of land to be developed into the Sole Bay Health and Care Home as an extension to the work already undertaken by CSIP.
- The practice had instigated the Sole Bay Care Fund, this was an independent registered charity run by local trustees to provide short term emergency care, resources and equipment not normally funded by the NHS or Social Services. The fund provided immediate care and support to those patients with an acute medical or social care need and in many cases was effective in reducing unnecessary hospital admissions by providing short term care in the home or as near to home as possible.

However there were areas of practice where the provider should make improvements:

- Record verbal complaints in order to widen shared learning.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. 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 patients' mental 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. Staff worked with multidisciplinary teams to meet patients' needs.

Are services caring?

Outstanding

The practice is rated as outstanding 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 and positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's' choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent

Summary of findings

appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

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

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice was rated as outstanding in the domains of caring and well-led. These ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked closely with the community matron and palliative care team and actively encouraged and helped patients to remain at home should they wish to in their last weeks and days.

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

Clinicians administered flu vaccinations at flu clinics and opportunistically and flu vaccination rates were in line with national averages. A local carers' support service had attended the practice to promote support services and signpost patients and their relatives to other services.

The practice had instigated the Sole Bay Care Fund, which was an independent registered charity run by local trustees to provide short term emergency care, resources and equipment not normally funded by the NHS or Social Services. The fund provided immediate care and support to those patients with an acute medical or social care need and in many cases was effective in reducing unnecessary hospital admissions by providing short term care in the home or as near to home as possible. The fund raised money by donations and legacies and by organising events such as sponsorship for marathons, which we saw staff and members of the patient participation group were very active in participating.

People with long term conditions

Outstanding ☆

The practice was rated as outstanding in the domains of caring and well-led. These ratings apply to everyone using the practice, including this population group. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when required. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those patients with the

most complex needs, the named GP worked with the community matron and relevant health and care professionals to deliver and ensure a multidisciplinary package of care was available when needed. For example we saw the Sole Bay fund had enabled people with long term conditions to stay in their homes when their health deteriorated.

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

The practice nurses worked with patients to manage long term conditions and recalled patients with conditions such as asthma and diabetes. The nurses maintained their training in this area to ensure they complied with best practice and the most recent guidelines. One GP utilised a risk profiling computer search software to identify patients who had a high risk of hospital admission, overdue screening or were put at risk because of their medications. The evidence from these searches was used to inform clinical management of these patients and ensure their safety

Families, children and young people

Outstanding ☆

The practice was rated as outstanding in the domains of caring and well-led. These ratings apply to everyone using the practice, including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Outstanding ☆

The practice was rated as outstanding in the domains of caring and well-led. These ratings apply to everyone using the practice, including this population group. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these

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

People whose circumstances may make them vulnerable

Outstanding ☆

The practice was rated as outstanding in the domains of caring and well-led. These ratings apply to everyone using the practice, including this population group. Double appointment times were offered to patients who were vulnerable or with learning disabilities. Carers of those living in vulnerable circumstances were identified and offered support which included signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. 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 monthly multi-disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible community psychiatric nurses to discuss vulnerable patients.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice was rated as outstanding in the domains of caring and well-led. These ratings apply to everyone using the practice, including this population group. The practice was aware of the number of patients they had registered with dementia and additional support was offered. This included those with caring responsibilities. A register of patients living with dementia was maintained and their condition regularly reviewed through the use of care plans. All 73 patients on the dementia register had been reviewed in the last 12 months. Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required.

Patients were signposted to support organisations such as the mental health charity (MIND) and the community psychiatric team for provision of counselling and support. All the staff we spoke with had an understanding of the Mental Capacity Act and their role in implementing the Act. There was a system in place to follow up patients who had attended accident and emergency (A&E) where they might have been experiencing poor mental health. There were 57 patients on the mental health register, of these 55 had been seen and reviewed in the last year. 36 patients on the register were eligible under QOF for a care plan and of these patients, 30 had a

plan in place with the remaining six patients scheduled for a care plan to be completed. For the 21 patients who were not eligible for a care plan, we were told 11 were in remission, two patients were classed as excluded, two patients had a dementia care plan and six were due further reviews as they also may also be classed as in remission. Patients were sent regular reminders, we were told the practice did not just invite them for a review for a set number of times.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing in line with local and national averages. There were 119 responses and a response rate of 47%.

- 87% find it easy to get through to this surgery by phone compared with a CCG average of 81% and a national average of 73%.
- 92% find the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 61% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 66% and a national average of 60%.
- 92% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 100% say the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.
- 85% describe their experience of making an appointment as good compared with a CCG average of 79% and a national average of 73%.
- 59% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 63% and a national average of 65%.
- 61% feel they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards which were positive about the standard of care received. These findings were also reflected during our conversations with patients during our inspection. We spoke with five patients during our inspection. The feedback from patients was positive. Patients told us about the ability to speak or see a GP on the day and where necessary get an appointment when it was convenient for them with the GP of their choice. We were given clear examples of effective communication between the practice and other services. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing, reception and the management teams were all very approachable and supportive. Patients felt confident in their care and liked the continuity of care they received at the practice. The patients told us they felt their treatment was effective and professional and they were very happy with the service provided. We also spoke with members of the patient participation group (PPG), this is a group of patients registered with the practice who have an interest in the service provided by the practice and who liaise with the practice through emails, letters and face to face. We were told they could not fault the care they had received. Patients were very positive about the new premises and the charity work the practice undertook to support the community matron to provide care to vulnerable patients in the community.

Areas for improvement

Action the service SHOULD take to improve

- Record verbal complaints in order to widen shared learning.

Outstanding practice

- The Southwold Care Services Improvement Partnership (CSIP) project reflected the complex needs of the older population, with the majority of individuals supported being over 85yrs. The practice

was in the process of discussions with the clinical commission group for an adjoining plot of land to be developed into the Sole Bay Health and Care Home as an extension to the work already undertaken by CSIP.

- The practice had instigated the Sole Bay Care Fund, this was an independent registered charity run by local trustees to provide short term emergency care, resources and equipment not normally funded by the NHS or Social Services. The fund provided immediate care and support to those patients with an acute medical or social care need and in many cases was effective in reducing unnecessary hospital admissions by providing short term care in the home or as near to home as possible.

Dr Castle & Partners, Sole Bay Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr Castle & Partners, Sole Bay Health Centre

Dr Castle and Partners also known as The Sole Bay Health Centre, provides general medical services to approximately 5,059 patients in the coastal, rural area of Southwold. Treatment and consultation rooms are situated on the ground floor. There is a lift and available for patients to access the first floor area and treatment rooms. Parking is available with level access and automatic doors. The practice population for patients over 85 years was four times the national average and three times the local CCG average.

The practice has a team of four GPs. All four GPs and a nurse practitioner are partners, meaning they hold managerial and financial responsibility for the practice. There is a team of four practice nurses, and one health care assistant who run a variety of appointments for long term conditions, minor illness and family health. A community matron is also attached to the practice as part of a pilot project to improve access to health and social care needs.

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

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.00am and 6.30pm, Monday to Friday. Appointments are from 8.50am every morning to 12 noon and from 3.30pm to 5.20pm daily. In addition to appointments that can be booked from three to six months in advance, urgent appointments are available for people who need them.

Branch Surgeries were held on a Thursday afternoon at Wenhaston Village Hall and a Wednesday afternoon at Walberswick Village Hall. Patients were able to contact the main surgery reception to book an appointment.

When the practice is closed patients are directed to the NHS 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned

Detailed findings

inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

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

How we carried out this inspection

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

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

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

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

The inspection team :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC's intelligent monitoring systems.
- Carried out an announced inspection visit on 24 November 2015.
- Spoke with staff and patients.
- Spoke with members of the patient participation group.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

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

Staff we spoke with could give examples of learning or changes to practices as a result of complaints received or incidents. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. The practice had undertaken an audit of all significant events in 2014. This audit included the analysis of 42 significant events, but was stopped after 21 significant events were reviewed as identified patterns emerged and highlighted areas where the practice's significant event process required improvement. For example whilst staff awareness of significant events was good, gaps were apparent in the reporting and recording process. The practice put an action plan in place to ensure robust recording, review and evidence of change being implemented and disseminated to all staff. The records we reviewed since the audit showed the practice had managed these consistently over this time and so could show evidence of change being implemented, learning disseminated to staff and a safe track record.

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

Overview of safety systems and processes

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

- The practice had systems to manage and review risks to vulnerable children, young people and adults. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to Safeguarding level 3. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They recorded safeguarding concerns and knew how to contact the relevant agencies, in working hours and out of normal hours. The practice had an appointed dedicated GP as lead for safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. The practice was engaged in reviewing and improving safety and safeguarding systems. The practice demonstrated good liaison with partner agencies in relation to safeguarding patients and health visitors, district nurses, school nurses and midwives were consulted with if any concerns arose. 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.
- Notices were displayed in the waiting room, advising patients that chaperones were available, if required. The practice manager confirmed that only nurses acted as chaperones and we saw they were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were maintained. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had

received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security).
- Regular medication audits were carried out with the support of the local clinical commissioning group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. We saw the practice had a history of low, cost effective prescribing. GPs attended the monthly CCG prescribing meetings. GPs ran searches to identify patients on high risk drug combinations, results or other markers so that they could act on them and intervene.
- The practice had appropriate written procedures in place for the production of prescriptions that were regularly reviewed and accurately reflected current practice. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We saw processes in place for managing national alerts about medicines, such as safety issues. Records showed that the alerts were distributed to relevant staff and appropriate action taken. There was a clear system for managing the repeat prescribing of medicines and a written risk assessment about how this was to be managed safely. Patients were able to phone in for repeat prescriptions, as well as order on line, in person, by post or via a chemist, and have their prescription within 48 hours. Changes in patients' medicines, for example when they had been discharged from hospital, were checked by the GP who made any necessary amendments to their medicines records. This helped ensure patients' medicines and repeat prescriptions were appropriate and correct. We checked treatment rooms, medicine refrigerators and GPs' bags and found medicines were safely stored with access restricted to authorised staff. Suitable procedures were in place for ensuring medicines that required cold storage were kept at the required temperatures. Stocks of controlled drugs (medicines that have potential for misuse) were managed, stored and recorded properly following standard written procedures that reflected national guidelines. Processes were in place to check medicines were within their expiry date and suitable for use. Out of date and unwanted medicines were disposed of in line with waste regulations. Blank prescription forms and paper were handled according to national guidelines and were kept securely.
- Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced in line with national guidance.PGDs were up to date and there were clear processes in place to ensure the staff who were named in the PGDs were competent to administer vaccines.
- Recruitment checks were carried out and the three files we reviewed showed that appropriate recruitment checks had been undertaken prior to staff's employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). We saw that where a lapse in registration had been identified the practice had identified the error and put procedures in place to rectify and ensure further lapses did not occur.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

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

The practice had comprehensive systems in place to manage patients who were either about to access or had accessed secondary care (for example, hospitals). The practice was proactive in monitoring referrals to and reviewing patients recently discharged from secondary care. The practice population for patients over 85 years was four times the national average and three times the local CCG average. Accident and emergency admissions for the period October 2013 to September 2014 were 176.3 in comparison to a national average of 331.5. In addition emergency admissions during the same period were 79.51, this was also below the national average of 91.3. The practice felt this was in part due to the rural location of the practice population and the distance to the local hospital services and in part to the support provided to patients by the team and the community matron to remain in their home.

The practice had a system in place to follow up two week or urgent referrals to ensure they had been received and an appointment confirmed with the patient. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 95.7% of the total number of points available, with 7.5% exception reporting. This was 0.4 percentage points below CCG average of 11.5% and 1.7 percentage points below national average of 9.2%. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed;

- Performance for diabetes related indicators was better in comparison to the CCG and national average. The practice achieved 95.3%; this was 4.5 percentage points above CCG average and 6.1 percentage points above national average.
- Performance for hypertension, learning disabilities, dementia, cancer, chronic kidney disease, epilepsy and heart failure indicators amongst others was better in comparison to the CCG and national average with the practice achieving 100% across each indicator.
- The dementia diagnosis rate was below the national average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to ensure improved care, treatment and outcomes for patients. The practice conducted a number of clinical audits, we looked at two. Both were completed audits where the

Good

Are services effective?

(for example, treatment is effective)

improvements made had been implemented and monitored. For example; as part of the national initiative to improve dementia diagnosis the practice was provided with data relating to dementia diagnosis rates against a national target of 70%. The practice's November 2014 diagnosis rate was 45.8%. With a high proportion of older patients the practice undertook an audit to establish correct diagnosis, read coding of the diagnosis and care provision for this population group. Results were analysed and discussed in clinical meetings and learned from, vulnerable patients with a potential diagnosis were identified on their computer records. This was then re-audited in March 2015 and again in October 2015. The results of the audit in March 2015 showed the diagnosis rate had improved from 45.8% to 52.84%, as improvements appeared steady, current actions were agreed and no further changes required. In October 2015 the re-audit showed the diagnosis rate had dropped to 50.6%, the cause of this was identified as patients moving out of the area into supported living or were at the end of life. The practice had put in place a revised action plan which included, continued monitoring of patients, identifying patients on the computer records, the community matron reviewing all patients living in care homes and a further re-audit to take place in March 2016.

Other audits included the safe monitoring of patients prescribed blood thinning medicines, audits of patients with chronic diseases for example an audit of patients with chronic obstructive pulmonary disease and optimisation of the treatment provided, patients on thyroid medicines (a previous QOF indicator no longer reviewed under QOF) and children on safeguarding registers; reviewing the recording of attendance of the patient and family members at the practice. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. We saw that mostly all staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

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

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

The practice team expressed concerns as previously they were not always advised when patients were admitted to hospital by the out of hours' service and equally they were not always advised when patients were discharged. We were told that following a significant event, the practice had systems in place to contact all those patients discharged when they received their discharge letter to ensure care was in place or to ascertain if any other problems had arisen. Also, we were told patients were very proactive and either they, or a family member, would contact the community matron to advise the practice they

were in hospital. This then enabled the practice to discuss the care with the hospital. However we were told there were still times when the practice were left with a crisis or urgent discharge to manage.

Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

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

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

Health promotion and prevention

Patients who might be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Patients were then signposted to the relevant service. For example patients who might benefit from weight management support were signposted to a local support group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was over 80%, which was comparable to the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds were between 83% to 100% with an average uptake of 97%; for those over two to five years 83% to 100% with an average uptake of 97%. Flu vaccination rates for the over 65s were 75.5%, and at risk groups 50.4%. These were comparable to CCG and national averages. There was a register of learning disability patients who were invited for an annual health check with their GP; the learning disability community nurse was informed of those who failed to make an appointment. We saw that of the 17 patients on the practice learning disability register, over half had received a health check and their care plans had been reviewed since April 2015, the remaining patients had an appointment scheduled for their review.

The practice had a high level of consideration for the care of its patients with long term conditions. The practice had achieved high results for its QOF indicators and had a policy to rarely exempt patients. In addition to monitoring patients on its QOF registers the practice had developed a range of searches that were regularly run to target conditions and patients that were not included under the QOF. These included patients taking a range of medicines or with a condition that were omitted. For example;

- Patients on a blood thinning medicine who had not received a blood test in the last three months.
- Patients taking thyroid medicine who had not received a recent monitoring blood test.
- Patients taking disease monitoring anti-rheumatic medicines (DMARDS)

These searches gave the practice an oversight of patients who might otherwise not be reviewed by the usual QOF

Good

Are services effective?

(for example, treatment is effective)

and practice registers to ensure they received appropriate care and treatment. There were systems in place to ensure patients were contacted if they failed to return following abnormal test results.

Patients had access to appropriate health assessments and checks. These included health checks NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

Both of the patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with three members of the patient participation group (PPG) on the day of our inspection. They told us they were very happy with the care provided by the practice and said their dignity and privacy was respected. In addition they described their effective involvement with the work undertaken by the Sole Bay Care Fund and the support this provided to the local community. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. We read letters from patients' families who described the excellence of the palliative care provided to their relatives.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was well above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 97% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 88% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG and national average of 95%
- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 92% patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 95% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Notices in the patient waiting room told patients how to access a number of support groups and organisations. There were also a number of services available within the practice. The practice worked closely with physiotherapists and mental health link workers, and promoted provision of these services from the premises where possible. An exercise instructor was available at the practice to support weight management. Local midwives provided clinics at the practice, hearing aid services were available and diabetic eye screening services attended the practice annually.

Are services caring?

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

Through speaking with staff, patients and from reading patients' comments and letters from patients' families we found there was strong focus on the care of patients within the practice. Personalised and optimal patient care was an overriding factor in all management decisions and the practice utilised every opportunity to improve the service they offered for the patients who used them. The practice had an overriding view of how they could improve access and outcomes for their patient population, with a focus on those in their community with limited access to health services. For example, as detailed throughout the report, the support offered to patients through the community matron and the Sole Bay Care Fund to provide such services as; carer support, the use of equipment where required to ensure patients were able to remain in their home and transport services for those living in rural areas who required access to care and treatment.

We saw that where patients had an end of life care plan the practice had worked with the multidisciplinary team to support the patient's choices. For example, we saw there was a high percentage, 60% of patients whose end of life was in their own home, with 10% in the local community hospital. In addition clinicians described how the practice focus around health promotion to ensure longevity and quality of life had contributed to a low local mortality rate.

Patient and carer support to cope emotionally with care and treatment

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

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. These cards were created and produced by the practice; families were visited by their GP and the community matron to meet the family's needs and/or by giving them advice on how to find a support service.

One GP at the practice was an instigator for the Southwold Care Services Improvement Partnership (CSIP). This was a pilot to provide a new approach to complex care delivery closer to patients' homes. The community matron and senior social worker were recruited to manage the project. This project provided an oversight of an patient's total care needs and the facilities to 'pull together' an holistic and effective package of care. This included medical support, care agencies, occupational therapists, rehabilitation support workers, physiotherapists, mental health support workers and where appropriate local admissions preventions services (these care teams are able to provide support to patients in their home for a time period). A major part of the project was also to provide support to the informal unpaid carers, such as partners, children or neighbours in isolated rural communities. In addition the team regularly visited older patients with long term conditions to encourage management of their medicines, and health review. The team attended weekly multidisciplinary team meetings to review upcoming discharges and ensure facilities were in place to manage discharged patients care in their homes.

As a result of this service the practice developed the Sole Bay Care Fund, this was a registered charity set up by the practice to provide short term emergency care, resources and equipment not usually funded by the NHS or Social Services to support those patients with an acute medical or social need, or to prevent unnecessary hospital admissions by providing short term care in the home or as near to home as possible.

For example the charity leased accommodation to support patients from residential care, hospital or following injury to build their confidence and provide support during their recovery. At the time of our inspection the charity had supported 20 patients through this accommodation, with 12 moving into their own residence. The charity provided a rented stair lift to enable patients on end of life to remain in their own home, paid for the hire of taxis with wheelchair access to enable patients to travel to respite care nearer their families, and paid for admission to urgent short term respite care including to care homes where patients could take their dogs. The outcome from this being an avoidance of hospital admission, delayed admission to long term residential care and providing families with the support and the opportunity for respite. In addition the charity funded carers, to provide respite for families and enable families to either go shopping for a few hours each week or to have lunch with friends. We were told the practice tended to use Sole Bay Care Fund for the first couple of

Outstanding ☆

Are services caring?

weeks to make an ongoing assessment of the patients' needs, by using the same carer most days, the practice was able to review the total care needs of the patient, their carers and any environmental issues.

This enabled families and the patients to build up a relationship with the care team should emergency care be required. After this the practice were then able to provide Social Services with a complete assessment of the patient's needs and offer a full and frank discussion with the patient concerned, the family and next of kin, for them to make an informed choice about how they wished their care to be provided. The Community Matron helped with applications for attendance allowance and carers' allowance. The care package was then be tailored to fit the patient, rather than the patient having to fit in with the care package offered.

The charity raised money by organising events, donations and legacies of which we saw staff and PPG members were actively involved.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG and other health organisations to plan services and to improve outcomes for patients in the area. For example, the practice worked with a community matron scheme to ensure

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

- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice reviewed patient admissions data monthly. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. We saw that the practice had a tracking system in place which ensured patients' referrals were actioned.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative care patients. Meetings were minuted and audited and data was referred to the local CCG.
- The practice worked closely with the medicines management team towards a prescribing incentive scheme (a scheme to support practices in the safe reduction of prescribing costs).
- Online appointment booking, prescription ordering and access to basic medical records was available for patients.
- Chlamydia test kits were available at the practice.
- Emergency contraception was available at the practice.
- The practice worked closely with community midwives, physiotherapists and mental health link workers, and promoted provision of these services from the surgery premises where possible. For example local midwives provided clinics at the practice, hearing aid services were available and diabetic eye screening services attended the practice annually.
- An exercise instructor was available at the practice to support weight management, alcohol reduction and smoking cessation and could refer patients for further support and guidance.
- The practice provided general medical services for students at a local boarding school.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.50am to 12 noon every morning and 3.50pm to 5.20pm daily. In addition to pre-bookable appointments that could be booked up to six months in advance, urgent appointments were also available for people that needed them. Home visits were available for patients who required them; we were told the practice took a great deal of pride in the provision of care they offered patients in the end of life. The practice worked closely with the community matron and palliative care team and actively encouraged and helped patients to remain at home should they wish to in their last weeks and days. The palliative care team meetings helped ensure this happened. Clinicians described the systems the practice put in place for vulnerable patients and those patients on end of life to ensure they were supported through their end of life wishes.

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

- 100% of patients said their last appointment they got was convenient compared to the CCG average of 94% and national average of 92%.
- 71% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 75%.
- 87% patients said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 85% patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 59% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63% and national average of 65%.

Branch Surgeries were held on a Thursday afternoon at Wenhaston Village Hall and a Wednesday afternoon at Walberswick Village Hall. Patients were able to contact the main surgery reception to book an appointment.

Listening and learning from concerns and complaints

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

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

All staff were aware of the complaints procedure and complaints forms were readily available at reception and the procedure was published on the practice website.

Patients we spoke with had not had any cause for complaint. We looked at five complaints recorded in the last 12 months and saw that these had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice. We saw the practice aimed to resolve any complaints swiftly and effectively and learn from what happened. As a result most were dealt with at the verbal stage. However there were no procedures in place for recording these to identify any trends or training needs.

A summary of each complaint included, details of the investigation, the person responsible for the investigation, whether or not the complaint was upheld, and the actions and responses made. We saw that complaints had all been thoroughly investigated and the patient had been communicated with throughout the process.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for its patients. This included a mission statement to;

- To provide a modern, accessible, caring and flexible service to the community.
- To provide individualised evidenced based care that reflected quality and excellence throughout all services.
- To maintain a multi-skilled team approach in delivery of primary care services.
- To ensure a culture of happy healthy staff and partners caring for each other and the patients.

The practice values were driven by the management team and embraced by all practice staff we spoke with. These included the extension of a model of a traditional general practice in a well organised service. Feedback from staff, patients and the meeting minutes we reviewed showed regular engagement took place to ensure all parties knew and understood the vision and values.

A five year business plan was in place and this included a supporting action plan demonstrating a commitment to continuous learning and development. For example, a three year staff succession and review plan, the capacity of the building to develop further clinics and services including dentistry and palliative day care treatments.

There was an on-going drive to deliver integrated care and enhance services for patients. For example, prior to the closure of the community hospital and the relocation of the practice to new purpose built premises, we were told the practice had engaged in 12 years of planning and public engagement and had worked closely with the contractors, the PPG and patients in the design and development of the new premises, with a vision to work with a wider healthcare team both in the community and from the new premises in new models of care provision for the area. The practice recognised the high level of admissions that occured at weekends through out of hours referral and was in the process of developing a practice led 'out of hospital team' in the future to manage these.

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

Governance arrangements

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

- There was a clear staffing structure, staff were aware of their roles and responsibilities. This included designated lead roles for staff to ensure accountability. Staff we spoke with felt valued and supported by the GPs and management team and described an open culture throughout the practice. GP and nurses partners had lead responsibilities for areas such as safeguarding, infection control and care related to patients with dementia. The nurse practitioner partner was the lead partner for hearing impairment.
- There was a comprehensive range of policies to ensure the safe and effective running of the practice. There was a schedule in place to ensure policies were regularly reviewed when required. The schedule ensured policies were up to date and where appropriate in line with relevant guidance. Staff had access to policies and were trained to ensure the policies were implemented appropriately.
- There was a comprehensive understanding of the practice's performance. The practice used a range of information which included peer review, performance data, feedback on quality, information and feedback from staff and patients to continually monitor its performance and assess areas for improvement. There was a programme of continuous clinical and internal audit to monitor quality and to make improvements to ensure patients received safe care and treatment. The practice held weekly meetings where audits, NICE guidelines, prescribing updates, recent deaths, new cancer diagnoses and acknowledged errors and mistakes were discussed. The practice took part in regular training events organised by the CCG. In addition we saw the practice had taken part in an analysis of significant events with a visiting clinical consultant.

Are services well-led?

Outstanding ☆

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

- The practice had completed reviews of incidents, compliments and complaints. Completed audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment. Where audits had taken place, these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.
- There were robust arrangements for identifying, recording and managing risks. Action plans were in place to address improvement in areas identified. For example the practice was aware and had strategies in place to manage the seasonal increase in it patient population, staff rotas, appointment scheduling and access to other services were regularly reviewed and adapted to meet the demand from seasonal temporary patients.

Leadership, openness and transparency

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

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

We saw from the minutes of team meetings that all staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Every member of staff we spoke with were positive and enthusiastic about working in the practice. The GPs outlined an ethos of good communication across all staff.

The practice was committed to teaching medical students from the University of East Anglia Medical School and training GP registrars. These are fully qualified doctors who were gaining further experience in general practice.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys, complaints received, the Friends and Family test, and personal contact with patients and local health care providers. The practice manager told us there were limited responses to the friends and family test questionnaires. However, we saw that of the 15 responses received from January 2015 to November 2015, 13 respondees were 'likely' or 'extremely likely' to recommend the practice.

The practice PPG met on a quarterly basis and was made up of representatives from the practice catchment area, (this is a group of patients registered with the practice who have an interest in the service provided by the practice and who liaise with the practice through emails, letters and face to face) and had made efforts to engage with the various population groups representative of the practice patient population. For example the practice's charity encouraged patients to suggest and support various activities and fund raising events, such as the choir, plant and cake sales, and second hand book table in the reception area to support the work undertaken by the community matron. The plant sale had at the time of our inspection, raised £900 for the charity. Representatives we spoke with described their effective involvement with the work undertaken by the Sole Bay Care Fund and the support from the proceeds raised from the various activities they took part in provided to the local community.

In addition the PPG carried out patient surveys and submitted proposals for improvements to the practice management team. Following the 2014/2015 PPG survey the practice worked with the PPG and had put in place a nine point priority action plan. Actions included;

- Completion and relocation to the new build.
- Improvements to the downstairs waiting area.
- Improvements to patient satisfaction by reducing waiting times.

Are services well-led?

Outstanding ☆

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

- Improvements to the lowest performance areas as highlighted in the current GP patient survey results.
- To work with other community organisations to represent, safeguard and develop local healthcare provision. In addition raising public awareness through public meetings.
- To encourage on-line repeat prescribing.
- The appointment of a new partner.
- Assess the outcomes for the CQC inspection.
- Examine ways to improve patient confidentiality.
- Undertake a 2015/2016 patient survey.

This also outlined progress made in the previous year from the 2013/2014 survey. These actions were approved and signed off by the PPG.

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

Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice provided support to patients to remain in their own home, as referred to previously in the report the work undertaken by the Southwold Care Services Integrated partnership (CSIP) project, the community matron and the practice charity to raise funds to support this work and 'fill in' the gaps for services not otherwise provided by the NHS or Social Services.

The CSIP project reflected the complex needs of the older population, with the majority of individuals supported being over 85yrs. The practice continued to assess and monitor the needs of the local community. A recent report by the practice confirmed that many patients on the CSIP caseload were not seen by the district nursing team as their care was complex and more chronic disease management, physical assessment and social care assessment than 'task orientated nursing'. The practice recognised the need for future, forward care of patients requiring highly skilled nurses in clinical assessment and management roles with more nurses who were independent prescribers and able to manage the medical, social and nursing needs of individuals. The practice had also recognized the need for a dedicated team of local carers who could deliver individualized care to the standard that the practice demanded. The practice was in the process of discussions with the clinical commission group for an adjoining plot of land to be developed into the 'Sole Bay Health and Care Home' as an extension to the work already undertaken by CSIP.

The practice was a teaching and training practice. The practice had successfully recruited a new partner in September 2015; this partner joined the practice 14 years after their GP father retired from the surgery.