Parish Fields Practice

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 17 November 2014 as part of our new comprehensive inspection programme.

Parish Fields Practice is located in a building which is shared with another GP practice in Diss and serves a population of around 7600.

The overall rating for this practice is outstanding. We found the practice was good in the safe, caring and well led domains and outstanding in the effective and responsive domains. We found the practice provided outstanding care to patients in vulnerable circumstances and families, children and young patients. We found that the practice provided good care to older patients, patients with long term conditions, working age patients and patients experiencing poor mental health.

Our key findings were as follows:

- The practice had a system for reviewing and responding to safety alerts and significant events.
- Staff took account of changes in national guidance when planning patient care.
- Staff had access to training to update their skills.
- Practice staff provided proactive and tailored services to support vulnerable patients
- The practice had a robust governance structure in place with designated lead and administrative staff for a range of areas, alongside a range of different meetings for staff.
- Staff spoke of a culture of quality improvement and learning through partnership working
- The practice was not afraid to challenge local commissioning arrangements in order to improve outcomes for patients

We saw several areas of outstanding practice including:

- The practice was working with Norfolk and Norwich University Hospital and the University of East Anglia as part of a pilot project to better identify patients at risk of type 2 diabetes and to reduce the risk of these patients developing type 2 diabetes through lifestyle change and motivational support. We saw evidence that clinical audit work around gestational diabetes had enabled the practice to identify more patients who were at risk and to support them with lifestyle

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changes during pregnancy. The practice could demonstrate how their proactive partnership approach was achieving better outcomes for their patients.

- Parish Fields Practice had developed a clinical audit programme which was both comprehensive and embedded. The practice had completed an extensive scheme of clinical audit cycles, covering a broad range of clinical 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, both internall and externally. Staff spoke of a culture of quality improvement and continuous learning within the practice.
- The practice had identified the needs of its local population and engaged with partner agencies to secure improvements to services where these were identified. The practice recognised the dichotomy of wealth and deprivation that exists in Diss and the surrounding area. The practice held food bank vouchers for those who were in need and worked in partnership with the Trussell Trust (a community body which aims to alleviate hunger and poverty). Practice staff were particularly aware of children in need and they worked closely with the Clinical Commissioning Group (CCG), local schools and Public Health teams to ensure that children who may be vulnerable accessed services. Arrangements were in place to ensure that traveller families registered and that traveller children were immunised. Care and support were offered on site at a local women's refuge and across short term housing providers to ensure that the needs of these patients were identified and met. Strong and bespoke joint working arrangements were in place with the Norfolk Recovery Partnership to support patients with drug and alcohol addiction.
- The practice used information received to ensure patient care was being planned effectively. For example, the practice received hospital data on admissions and A&E attendances daily. This information was disseminated to the patient's named GP via email by an administrator within the practice. If a patient remained in hospital for more than seven days, the named GP rang the hospital to discuss the admission and to attempt to facilitate discharge. Patients were contacted by their named GP within 48 hours following discharge from hospital.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for safe. There were systems and processes in place for managing and responding to safety alerts. Staff learnt from any incidents and events that occurred in the practice and we found changes had been made as a result. Patients, staff and visitors were protected against the risk of health care associated infections. Arrangements were in place to manage emergencies. Staff understood their responsibilities to raise any concerns about patients who may be at risk. Staffing levels were appropriately managed and maintained.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services. Data showed that overall patient outcomes were either average or above average for the locality. Parish Fields Practice had developed a clinical audit programme which was both comprehensive and embedded. The practice had completed an extensive scheme of clinical audit cycles, covering a broad range of clinical areas. There was evidence that this had led to improvements in outcomes for patients. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely, to ensure care pathways reflected best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was also aware of patient's cultural background when assessing their needs. Staff understood the arrangements for gaining patient consent to treatment. Arrangements were in place to promote patient health. Staff had received training appropriate for their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were very satisfied with the care they received from the practice. We saw that the practice had taken steps to ensure information was accessible to patients. During our inspection we saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had identified the needs of its local population and engaged with partner agencies to secure improvements to services where these were identified. Practice staff

Summary of findings

went out of their way to provide proactive and tailored services to vulnerable patient groups, including those living in deprived circumstances. The practice openly challenged the local commissioning arrangements for the provision of care for mental health patients.

Patients were able to access routine appointments by booking in advance and urgent appointments were always available on the day. Children were offered same day appointments.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available. When complaints were made the practice responded and identified any learning as a result.

Are services well-led?

Good

The practice is rated as good for well-led. Staff strived to achieve the common goal of patient focused care. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population. Older patients were seen annually, or sooner depending on the complexity of their needs, by the nursing or medical team for health checks and to review their medicines. The practice had identified vulnerable older people who might experience a sudden deterioration in their health. This group of patients were offered regular health checks and, with the patient's consent, information was made available to the local out of hours and urgent care teams. Monthly multi-disciplinary meetings were held to identify the best ways to provide care to older people and, where appropriate, to avoid them going into hospital. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it. We saw that flu and shingles vaccinations were routinely offered to older patients to help protect them against these viruses and associated illnesses.We spoke with representatives from two nursing homes who told us that patients were supported to make informed decisions about their treatment and that the practice offered effective care to their residents. Older people we spoke with told us that they could get an appointment on the same day if they needed it and that they were satisfied with the care provided.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Arrangements were in place to ensure patients had a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the practice worked with relevant health and care professionals to support patients. The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice. For example, we saw the practice had recently responded to NICE guidance relating to the prescribing of medicines to treat epilepsy by brand only. The practice was working with Norfolk and Norwich University Hospital and the University of East Anglia as part of a pilot project to better identify patients at risk of type 2 diabetes and to reduce the risk of type 2 diabetes through lifestyle change and motivational support.

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Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Vulnerable families were proactively supported in a personalised way which helped address issues faced by both parents and children. We noted that the practice had adopted a particularly strong approach to safeguarding the interests of children living in poverty. All staff were trained to recognise the signs that a child might require extra support and the practice was able to give several examples of families they had worked with. Immunisation rates were relatively high for all standard childhood immunisations. Same day appointments were available as were appointments outside of school hours. The premises were suitable for children and babies. Practice staff maintained a register of children in need and they worked closely with the CCG, local schools, health visitors and public health teams to ensure that children who may be vulnerable accessed services. The practice employed a proactive approach to ensuring that traveller children were immunised.

Working age people (including those recently retired and students)

Good ●

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice provided appointments into the early evening. The practice provided online booking for appointments. Health promotion and screening that reflected the needs for this age group was taking place.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had a system for calling patients with a learning disability to attend for an annual health check.

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.

Care and support was offered on site at a local women's refuge and across short term housing providers to ensure that the needs of

Summary of findings

these patients were identified and met. Joint working arrangements were in place with the Norfolk Recovery Partnership to support patients with drug and alcohol addiction and we noted that this had led to improved outcomes for this group of patients.

The practice recognised the dichotomy of wealth and deprivation that exists in Diss and the surrounding area. The practice held food bank vouchers for those who were in need and worked in partnership with the Trussell Trust (a community body which aims to alleviate hunger and poverty).

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Clinicians provided empathetic and responsive care to patients with poor mental health. Patients experiencing poor mental health were invited to attend the practice for different physical health checks. The practice recognised that, due to financial constraint, significant gaps existed in local provision of mental health secondary care. Practice staff were proactive in challenging commissioning arrangements in order to improve outcomes for patients with mental health needs. Referrals to the local mental health trust were actively followed-up to ensure the best outcome for patients.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We received eight completed comment cards all of which were positive.

We spoke with fifteen patients during our inspection. The patients we spoke with told us that they trusted staff at the practice and that they felt that they received a good level of care. Nine patients expressed their opinion that the practice provided an outstanding service and that GPs and nurses went the extra mile to ensure that patients were seen and that their needs were met as conveniently and quickly as possible. Some patients told us that they sometimes had to wait a little longer to see the GP who knew them best, but they confirmed that they could always get an urgent appointment with another doctor if this was necessary. Patients confirmed that they were aware of the facility of a chaperone if they wanted one.

We spoke with three representatives of the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. We were told that they felt listened to by the practice.

Outstanding practice

- The practice was working with Norfolk and Norwich University Hospital and the University of East Anglia as part of a pilot project to better identify patients at risk of type 2 diabetes and to reduce the risk of type 2 diabetes through lifestyle change and motivational support. We saw evidence that clinical audit work around gestational diabetes had enabled the practice to identify more patients who were at risk and to support them with lifestyle changes during pregnancy.
- Parish Fields Practice had developed a clinical audit programme which was both comprehensive and embedded. The practice had completed an extensive scheme of clinical audit cycles, covering a broad range of clinical 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. Staff spoke of a culture of quality improvement and continuous learning within the practice.
- The practice had identified the needs of its local population and engaged with partner agencies to secure improvements to services where these were identified. The practice recognised the dichotomy of wealth and deprivation that exists in Diss and the surrounding area. The practice held food bank vouchers for those who are in need and worked in partnership with the Trussell Trust (a community body which aims to alleviate hunger and poverty).

Parish Fields Practice

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 advisor, second CQC inspector and a practice manager specialist advisor.

Background to Parish Fields Practice

Parish Fields Practice in Mount Street, Diss provides services to patients living in Diss and the surrounding villages.

The practice is a partnership of five GPs. One GP partner holds the role of senior partner within the practice. Of the five GP partners, four are male. The practice also employs four practice nursing sisters, a phlebotomist and a healthcare assistant. The clinical team is supported by a team of administrators and receptionists, as well as a practice manager.

The practice has a patient population of approximately 7,600.

GP appointments are available every weekday between 08.40 and midday and then from 14.30 until 18.00.

The practice has opted out of providing out-of-hours services and these services are available from another provider. The practice website clearly details how patients may obtain services out-of-hours.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

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

Before inspecting, we reviewed a range of information we held about the practice and asked other organisations such as the local Clinical Commissioning Group (CCG) and the NHS England Local Area Team. The CCG and NHS England are both commissioners of local healthcare services.

We carried out an announced inspection on 17 November 2014.

During our inspection we spoke with a range of staff; reception, administrative and clinical staff. We also spoke with patients who used the service, and three representatives of the Patient Participation Group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

We reviewed comment cards which we had left for patients and members of the public to share their views and experiences of the service. We also reviewed a range of different records held by the practice.

Good

Are services safe?

Our findings

Safe track record

The practice 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 practice had implemented systems for reporting and responding to incidents. We reviewed all serious untoward incident (SUI) reports that had been identified and recorded in the previous 12 months. We found they had been completed by GPs and dispensary staff on a range of incidents including prescribing, dispensing and clinical decision making. The reports included actions that had been taken in response to the incidents to reduce future recurrence and improve patient safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw evidence that the practice had managed these consistently over time and so could demonstrate a safe track record over time. Staff were aware of their responsibilities and the system for reporting significant events, and we saw changes as a result of incidents arising. Staff attended regular meetings where the outcome of significant events and any learning was discussed. Learning from complaints was also discussed.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. A slot for significant events was on the weekly clinical meeting and monthly staff meeting agendas. We saw evidence that the practice had reviewed actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. For example, a recent incident involving the identification of expired medicines within a GP bag had led to a review and adjustment of processes to reduce the risk of recurrence. All clinical and non-clinical staff we spoke with were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children and for domestic abuse and another GP partner was the lead for safeguarding of vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their role.

Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. Two members of staff we spoke with described recent incidents in which they had reported safeguarding concerns to the GP and the safeguarding lead. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

Systems were in place to ensure sharing of information with the local health visitor. We viewed the minutes of the monthly meetings to discuss children of concern and noted that documentation was detailed and thorough.

A chaperone policy was in place and information was clearly displayed in the waiting room, at reception and in consulting and treatment rooms. Chaperone training had been undertaken by nursing staff and two administrative staff who acted as chaperones when nursing staff were unavailable.

Robust procedures were in place to ensure that criminal record checks via the disclosure and barring service (DBS) were undertaken where necessary. Risk assessments of all roles and responsibilities had been completed to determine the need for a criminal record check.

Medicines management

The practice had a medicines dispensary located next to the reception and waiting area. The dispensary was used by patients who lived more than one mile from a dispensing pharmacy. The practice dispensed medicines to over half of its patients. The dispensary had a dedicated manager who was a qualified dispenser and a team of staff who had been trained to dispense medicines safely.

Good

Are services safe?

The practice had policies and procedures in place to ensure the effective management of medicines. These policies had been reviewed within the last 12 months. A very wide range of standard operating procedures were in place and we saw that these had been updated on a rolling basis. We noted that dispensary staff were knowledgeable about dispensary protocols and could swiftly locate any procedure we requested to see. We saw the procedure governing the management of controlled drugs which ensured that these drugs were stored and handled in line with legal requirements. We noted that the vaccine handling and cold chain protocols were appropriate and that staff understood their significance.

Robust processes were in place to support the management of repeat prescriptions. Repeat prescription requests could be made in writing to the practice, via the practice website or by completing the repeat prescription request section of a previously dispensed prescription. All repeat prescriptions were generated directly by the patient's own GP. The repeat prescription was then printed and signed by the GP only after the GP had checked the medicine had been correctly dispensed. The batch number and expiry date of all medicines dispensed to patients was recorded. Private prescriptions, for example, for anti-malaria medicines, were recorded appropriately. Blank prescription pads were stored securely.

Rigorous auditing and review processes were in place to monitor the safety of prescribing and dispensing of medicines. Dispensing errors had been clearly recorded and investigated, with investigation outcomes and learning points noted. For example, a patient had been dispensed an incorrect medication. We saw that the incident had been soundly recorded and the advice of the duty doctor had been sought immediately. We spoke with three members of dispensary staff who all explained the steps they now took in order to avoid dispensing incorrect medication, including checks by a peer dispenser.

The practice received additional support from a practice support pharmacist from the local clinical commissioning group who visited the practice monthly to carry out reviews of medicines prescribing. The clinical commissioning group also provided pharmacists who visited the care homes supported by the practice, to undertake reviews of patients prescribed a number of different medicines.

We checked medicines stored in the treatment rooms and fridges and found that they were stored appropriately. There was a clear policy for maintenance of the cold chain in the event of power failure, including the use of cool box containers.

Cleanliness and infection control

Systems were in place to reduce the risks of the spread of infection. A designated member of staff was the practice infection control lead person. They demonstrated a good understanding of their role. Infection control policies and procedures were in place. All staff had received training in infection control processes and were aware of infection control practices.

The practice had ensured they met the requirements outlined in the Department of Health Code of Practice on the Prevention and control of infections and related guidance 2010. Auditing of infection control processes was carried out annually. We saw the last audit had been completed in July 2014. Concerns relating to an external cleaning contractor had been noted within the audit and appropriate action taken.

We observed that all areas of the practice were clean and extremely well maintained. Hand washing notices were displayed in all consulting and treatment rooms. Hand wash solution, hand sanitiser and paper towels were available in each room. Disposable gloves were available to help protect staff and patients from the risk of cross infection. Spillage kits were available in clinical rooms and in the reception area. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor operations they performed.

We saw that the practice had arrangements in place for the segregation of clinical waste at the point of generation. Colour coded bags were in use to ensure the safe management of healthcare waste. An external waste management company provided waste collection services. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

Suitable arrangements were in place to reduce the risks of exposure to Legionella bacteria which is found in some

Good

Are services safe?

water systems. A comprehensive Legionella risk assessment had been completed. We saw that monthly testing of water temperatures was carried out and water outlets not used regularly were flushed through.

Equipment

A log of all equipment within the practice was in place. Regular service and calibration checks on equipment had been performed. We saw that portable appliance testing had been carried out to ensure the safety of all electrical equipment. Medical equipment including defibrillators and oxygen were available for use in the event of a medical emergency. The equipment was checked daily to ensure it was in working condition.

Staffing and recruitment

There were robust recruitment and selection processes in place. We reviewed a sample of four personnel files which confirmed that the required pre-employment information and checks had been obtained. These included a curriculum vitae or application form, photographic identification, references, and a professional registration check. The practice had undertaken risk assessments for all roles to determine the need for a criminal record check via the Disclosure and Barring Service (DBS). We saw that criminal records checks had been undertaken where appropriate. Up to date records of the hepatitis B immunity status of all staff were held within the practice.

Monitoring safety and responding to risk

The practice had considered the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of Legionella bacteria. All risk assessments had been recently reviewed and updated. We spoke with both clinical and non -clinical staff about managing risks and found that they had the skills to safeguard patient safety. We observed that the practice environment was organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked and sited appropriately.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including defibrillators and oxygen were available for use in the event of a medical emergency. The equipment was checked daily to ensure it was in working condition. All staff had received training in basic life support and defibrillator training to enable them to respond appropriately in an emergency.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines 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 may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations.

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

The practice had appointed both GP and nurse leads for specialist clinical areas such as diabetes and respiratory conditions. GPs and nurses were well supported in their specialist roles and described a culture of information sharing, transparency and continual learning. For example, the lead nurse for diabetes told us they had been supported in undertaking advanced training in diabetes. They met regularly with the lead GP for diabetes to review best practice guidelines and both regularly attended shared care meetings with secondary care services. The practice was working with Norfolk and Norwich University Hospital and the University of East Anglia as part of a pilot project to better identify patients at risk of type 2 diabetes and to reduce the risk of type 2 diabetes through lifestyle change and motivational support. The practice could demonstrate how their proactive partnership approach was achieving better outcomes for their patients.

The practice ensured that patients had their needs assessed and care planned in accordance with best practice. A review of 10 case notes included those of five patients with diabetes and five with respiratory conditions. We saw that all patients received appropriate treatment and regular review of their condition. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions.

The practice maintained and managed patients with a range of long term conditions in line with best evidence based practice. For example, we saw the practice had recently responded to NICE guidance relating to the prescribing of medicines to treat epilepsy by brand only. The practice had identified affected patients and all GPs had been informed of the changes required. Prescribing to these patients had been re-audited following a three month period to ensure guidance had been followed.

We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission, end of life care and a 'ceiling' (an upper limit) of care agreed by the patient. Care plans were given to patients to ensure their full involvement and to facilitate sharing of information with other services, such as out of hours services. We saw that care plans had been reviewed every three months or more frequently as required.

The practice referred patients appropriately to secondary and other community care services. The GP partners told us that referrals were regularly reviewed in conjunction with the clinical commissioning group.

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

Management, monitoring and improving outcomes for people

The practice achieved 98.5% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed well in comparison to the national and CCG averages.

The practice had a system in place for completing clinical audit cycles. Clinical audits are reviews which aim to

improve outcomes for certain patient groups. Parish Fields Practice had developed a clinical audit programme which was both comprehensive and embedded. The practice had completed an extensive scheme of clinical audit cycles, covering a broad range of clinical areas. This included gestational diabetes, dispensary services, prescribing of analgesics including non-steroidal anti-inflammatory drugs (NSAIDs) and prescribing within a shared care protocol. The practice was able to demonstrate that each clinical audit cycle was completed in order to demonstrate that improved outcomes had been achieved for patients. We saw the results of audits had been shared with both GPs and nurses within regular clinical meetings. Staff spoke of a culture of quality improvement and continuous learning within the practice. The practice was able to demonstrate how its audit work and changes to practice had led to improved outcomes for its patients, and particularly those patients with a long term condition.

The practice routinely collected information about patient care and treatment outcomes. For example, patients prescribed disease modifying anti-arthritic medicines were monitored by the practice through a shared care protocol with secondary care services. The practice held a register of these patients who were recalled for blood testing when required. An administrator within the practice managed this process with the patient's GP reviewing the blood results within 24 hours of receipt. The process was audited by the GP prescribing lead partner on a three monthly basis.

Effective staffing

New staff followed an induction programme and probationary period, followed by a formal review. This ensured that staff were familiar with practice procedures and competent to perform their duties. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding of children and vulnerable adults.

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, the practice had appointed a lead nurse for diabetes and a lead nurse for respiratory conditions. Both lead nurses had undertaken advanced training. The lead nurse for diabetes told us that three monthly shared cared meetings and attendance at an annual diabetes management conference provided opportunities for further updating of knowledge.

Reception and administrative staff had undergone training relevant to their role. For example, one administrator told us they had received training in customer care and data protection. Another administrator who had joined the practice within the last 12 months described their induction programme which included supervision, group training and e-learning programmes. Staff described feeling well supported to develop further within their roles.

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed this. A practice nurse told us they last had an appraisal with the lead GP partner in January 2014. This had included a detailed review of performance and the setting of objectives and learning needs. We saw evidence which confirmed this. All of the GPs within the practice had undergone training relevant to their lead roles, such as diabetes management and child safeguarding.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, the practice demonstrated they had developed effective working relationships with two local residential care homes which provided care for patients with dementia. Anticipatory care planning for those patients reflected the patients' wishes relating to hospital admission, end of life care and a 'ceiling' of care agreed by the patient.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and actioned by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. We saw the practice had a clear audit trail to ensure these processes were completed.

Referrals were made using the 'Choose and Book' service. We saw evidence of the practice's referral process and its

effectiveness. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Multi-disciplinary meetings which included palliative care nurses, health visitors, community psychiatric nurses and district nurses were held regularly. An example of the range of patients discussed included palliative care patients, children of concern to health visitors, those experiencing poor mental health and 'at risk' patients including patients who had experienced unplanned admission to hospital.

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 patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Electronic systems were also in place for making some referrals through the Choose and Book system.

Care plans were given to patients to ensure their full involvement in decision making and to facilitate sharing of information with other services, such as out of hours services.

The practice used information received to ensure patient care was being planned effectively. For example, the practice received hospital data on admissions and A&E attendances daily. This information was disseminated to the patient's named GP via email by an administrator within the practice. If a patient remained in hospital for more than seven days, the named GP rang the hospital to discuss the admission and to attempt to facilitate discharge. Patients were contacted by their named GP within 48 hours following discharge from hospital.

Consent to care and treatment

Patients we spoke with told us that the GPs and nurses always obtained consent before any examination took place.

The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment. We reviewed completed consent forms for the insertion of contraceptive implants and minor surgical excisions. These consent forms provided details of the risks presented to the patient and demonstrated that informed consent had been obtained.

Patients with learning disabilities 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 required and had a section stating the patient's preferences for treatment and decisions relating to end of life care where appropriate. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to consent. All GP and nursing staff demonstrated a clear understanding of Gillick competencies. (These help clinicians GPs and nurses to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions, learning disabilities and those experiencing mental health concerns. We saw that medical reviews for those patients took place at appropriately timed intervals. The practice also offered NHS Health Checks to all its patients aged 40-75. An administrator told us that all patients who met the criteria for these checks were contacted directly by telephone to encourage them to attend.

Health information was made available during consultation. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

There was a variety of information available for health promotion and prevention throughout the practice, in the waiting area and on the practice website. The practice had also developed an 'information room' for patients which was situated next to the reception and waiting areas. This provided a private room for patients to seek health promotion information and literature. The practice had installed an electronic blood pressure monitor and weighing scales within the room. These provided patients

Outstanding ☆

Are services effective?

(for example, treatment is effective)

with the opportunity to monitor their weight and blood pressure independently or to seek assistance from a member of the practice team for the readings to be recorded.

Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home. The practice had arranged additional Saturday clinics for patients to attend for their flu vaccinations. GPs told us they personally telephoned patients to educate them about the benefits of vaccination and encourage uptake. The practice had recently held a coffee morning in conjunction with a flu immunisation clinic to encourage uptake.

The nurses we spoke with us told us there were a number of services available for health promotion and prevention. These included child immunisation, diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, coronary heart disease (CHD), cervical screening, smoking cessation support, a health trainer service, gym referrals, a diabetes exercise project and travel vaccination appointments.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to provide us with feedback on the practice. We received eight completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were professional, supportive and caring. They said staff treated them with dignity and respect. We spoke with fifteen patients on the day of our inspection and three representatives of the patient participation group (PPG) prior to the inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

GPs and staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard. The practice provided a private 'information room' next to the reception area. This room was used to provide privacy for patients who wished to speak to a receptionist or other staff member, away from the reception desk. Staff told us it was also used by patients who were particularly upset or anxious prior to or following their appointment with the GP. A sign on the reception desk politely requested that patients waiting to speak with a receptionist stood away from the desk to allow the patient before them some privacy.

Staff respected patients and preserved their dignity and privacy. Privacy curtains were in place in every consultation room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that 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.

The national GP patient survey information, of July 2014, showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from this survey showed 91% of responding patients felt that their GP was either good or very good in involving them in care decisions. 94% of patients stated that the last time they spoke to a nurse, the nurse was good or very good at involving them in decisions about their care.

We were told that older patients were involved in their care planning, as were their carers where appropriate. End of life care planning was in place, which reflected patients preferred place of care at the end of their life. We saw that the care plans used for patients with a learning disability and for those for patients with a mental health problem were comprehensive.

Translation and interpretation 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 practice had a system for ensuring that all staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient.

Patients were supported by the practice when a close relative died. The waiting area included various information which sign posted people to support available including citizen's advice, counselling and bereavement services. A named GP visited patients towards the end of their lives and supported family members alongside the district nurse. Traumatic events such as a death or loss of a child during pregnancy were identified and support offered including signposting to other services. If the service was unable to meet the patient's needs they could refer the patient to trained counsellors and mental health support.

We spoke with a patient who was recently bereaved and they told us that their GP had supported the whole family well towards the end of their loved one's life. Staff we spoke with said that patients at the end of their life and their families were given support and signposted to counselling and bereavement services.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and the needs of the practice population were understood. The practice proactively supported certain patient groups to engage with the service, for example, special arrangements were in place to ensure that traveller families registered and that traveller children were immunised. Care and support was offered on site at a local women's refuge and across short term housing providers to ensure that the needs of these patients were identified and met. Joint working arrangements were in place with the Norfolk Recovery Partnership to support patients with drug and alcohol addiction. Practice staff had received training around domestic abuse and so were well placed to support patients who were affected.

The practice was working with South Norfolk Council to support older people to live as independently as possible. We noted that patients were proactively supported to live at home where this was appropriate. The practice was considering innovative ways to use resource from the Prime Minister's Challenge Fund to better meet the needs of its older population. Practice staff were aware of children in need and they worked closely with the Clinical Commissioning Group (CCG), local schools and Public Health teams to ensure that children who may be vulnerable accessed services.

There was a clinical lead for different areas of care, reflecting the Quality and Outcomes Framework (QOF). The Quality Outcomes Framework (QOF) provides a set of indicators against which practices are measured and rewarded for the provision of quality care.

The Patient Participation Group (PPG) was proactive and had challenged and supported the practice to improve. As a result, appropriate waiting room seating had been purchased to meet the needs of the population. The PPG had organised health promotion talks to support patients to achieve a healthier lifestyle. A recent PPG survey identified an issue around access for less mobile patients and there were plans to fit a handrail and seat. The PPG engaged with the community pharmacy to improve the service available to patients. Improvements had been made to the way that patients experience reception and booking appointments. PPG members involved themselves in patient complaints where the practice felt that this was appropriate and suggested improvements that could be implemented as a result.

Tackling inequity and promoting equality

The practice recognised the dichotomy of wealth and deprivation that exists in Diss and the surrounding area. The practice held food bank vouchers for those who are in need and worked in partnership with the Trussell Trust (a community body which aims to alleviate hunger and poverty). Vulnerable families were proactively supported in a personalised way which helped address issues faced by both parents and children. We noted that the practice had adopted a particularly strong approach to safeguarding the interests of children living in poverty. All staff were trained to recognise the signs that a child might require extra support and the practice was able to give several examples of families they had worked with.

The practice was able to provide information in languages other than English and an interpretation service was available for consultations as required. An induction loop was provided at the practice for patients who were hard of hearing or deaf. Patients who were homeless were able to use the practice's address to register as a temporary patient. Equality and diversity training had been provided to staff.

Access to the service

From the GP patient survey data of July 2014 the practice was in line with other practices in their Clinical Commissioning Group area for patients' ease of access in contacting the practice by telephone.

The practice opened for appointments from 8:30am to 6.30pm Monday to Friday. Patients who responded to the GP patient survey expressed satisfaction levels in line with the national average around the opening hours at the practice.

The out of hours service was carried out by another provider and information about how to access this service was found in the practice information leaflet and the practice website. The practice had a clear, easy to navigate website which contained detailed information to support patients including the arrangements for making and cancelling appointments, requesting and accessing repeat prescriptions and obtaining test results. Home visits for housebound patients and those too unwell to attend the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice were arranged as necessary. Patients were able to register as temporary residents and were supported to register if this was required. Travellers were able to register at the practice as patients unless registration as a temporary patient was more appropriate.

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.

The practice had a complaints leaflet advising patients how to complain and the practice website also supported online complaints. We looked at the complaints received in 2014 and found that these were handled appropriately and in a timely way. The practice maintained a log of complaints which included details of any learning. They also monitored complaints for themes and trends.

We saw that complaints were discussed at practice meetings. There was evidence of changes in practice as a result of complaints received, for example seating in reception, access to the building and ease of making appointments.

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 staff shared their ethos for the practice which was, 'To provide patient focused care within a caring environment, offering patients choice to be seen at the right time, in the right place with appropriate trained professional staff.' This philosophy was shared in the practice leaflet and on the website. Staff spoke about the importance of creating an open and honest culture in which challenge, innovation and learning could thrive. The practice had a clear focus on improving outcomes for their patients. They achieved this through reviews, audits and responding to feedback from staff and patients.

Governance arrangements

There was an effective governance framework in place to support the delivery of good quality care. Policies and procedures at the practice were shared across staff groups and there was evidence that the policies and procedures had been reviewed and updated appropriately.

There was a clear structure in place with a range of different staff across the practice taking lead roles. This included both administrative and clinical staff. The different measures/indicators within the Quality and Outcomes Framework were championed by staff leads. The Quality and Outcomes Framework is a voluntary annual reward and incentive programme for all GP surgeries in England. The staff we spoke with were clear about their roles and responsibilities, and to whom they were accountable.

There was also a system for managing variable performance of staff that was robust as well as fair and proportionate. We found evidence of this process being applied effectively.

The practice held regular governance meetings. We saw that items for discussion included significant events, complaints and compliments, health and safety and training.

Leadership, openness and transparency

It was clear from our interviews with the management team, the GPs and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care which put patients and their wishes first. This was reflected in the practice statement of purpose that was posted on the practice web-site. We also saw that there was a practice charter on the web-site that set out what patients had a right to expect from the practice and it was evident during our inspection that staff believed in and adhered to this.

Staff members we spoke with told us they felt their contribution to providing good quality care was valued. They told us that they welcomed the opportunity to raise issues with the GPs and the management team as part of the 'open door' policy. This was also reflected in the arrangements for training staff and an appraisal system that was supportive, meaningful and driven by individual objectives.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a Patient Participation Group which met regularly with the practice management and reception staff. The PPG is a group of patients registered with the practice who have no medical training but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. We met with three PPG members who described the work they had undertaken on behalf of patients. Achievements included replacement of waiting room seating and health promotion talks to support patients to achieve a healthier lifestyle. A recent PPG survey identified an issue around access for less mobile patients and the practice had plans to fit a hand rail and seat. The PPG engaged with the community pharmacy to improve the service available to patients. Improvements had been made to the way that patients experienced reception and booking of appointments. PPG members involved themselves in patient complaints where the practice felt that this was appropriate and suggested improvements that could be implemented as a result.

The practice had a whistleblowing policy which was available to all staff. Whistle blowing is when a former or current member of staff raises concerns about potential risk, malpractice or wrongdoing in their organisation. The whistle blowing policy also directed staff to other organisations from which they could seek help and advice if necessary.

Management lead through learning and improvement

The practice was effective in ensuring its staff performed well and operated within a learning culture. We have

Are services well-led?

Good

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

reported above that staff received annual appraisals that were relevant, meaningful and driven by objectives. The emphasis in this process was on development, promoting opportunities to learn and improve and on maintaining good clinical practice. This was mirrored in the practice's approach to monitoring quality and performance through the use of clinical audits and the review of significant events.