Stowhealth

Quality Report

Violet Hill House,
Violet Hill Road,
Stowmarket
Suffolk.
IP14 1NL
Tel: 01429 776000
Website: //www.stowhealth.com/

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Stowhealth Surgery on the 24 February 2015 and carried out a comprehensive inspection. Overall the practice is rated as outstanding.

Specifically, we found the practice was outstanding for providing responsive and well-led services and services for older people, people with long-term conditions and working age people (including those recently retired). We found the practice to be good for providing safe, effective, and caring services. It was also good for providing services for families, children and young people, people whose circumstances make them vulnerable and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored and appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. There was a strong learning culture within the practice. Staff had received training appropriate to their roles and any further training needs had been identified and planned for.
- Patients said they were treated with dignity and respect and were involved in decisions about their care and treatment.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patient and meet their needs.
- Patients were happy with the appointment system because they were able to get telephone advice or be seen the same day. The practice offered flexibility to help meet patients' needs for example, by arranging a

Summary of findings

call back at a time convenient with the patient. Continuity of care was promoted by providing patients with urgent appointments that day and usually with the GP who had dealt with the initial call.

- The practice had strong visible leadership and staff felt supported by the management and were involved in the vision of providing high quality care and treatment. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

- The practice provided a fully equipped gym with qualified fitness instructors to assist patients with improving their mobility, manage body weight and maintain a healthy lifestyle.
- The practice had responded to areas highlighted in the 2013 Patient Reference Group (PRG) survey, (this is a group of patients registered with the practice who have an interest in the service provided by the practice). These included inserting evacuation chairs in the stairwells, lowering sections of the reception desk for wheelchair users and providing all clinical rooms with electric couches. Action had been taken to improve these areas including systems to review and improve the appointment system.
- The practice had a clear vision that was shared and owned by all staff. Structured policies and processes were followed to deliver high standards of care. Performance and governance arrangements were proactively reviewed. Leadership responsibilities were delegated appropriately and staff were able to demonstrate this worked well in practice. The clinical and management team shared decision making (both clinical and non-clinical) and worked effectively through clear communication and mutual support. There was a strong culture of shared learning, achievement and improvement to ensure that patients' needs were met.
- The practice had won awards in recognition of its integrated approach to long term medical conditions (LTMC). The LTMC clinics were run weekly by a team of health care assistants, nurses and GPs all working together to ensure patients received a one stop medication and health condition review.

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

Importantly the provider should

- Improve the arrangements for the security of blank prescription forms and improve the security of medicines waiting to be collected by patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. When things went wrong these were investigated to help minimise recurrences. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. Patients, including children, who were identified as being at risk were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe. Premises were clean and risks of infection were assessed and managed. The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the local Clinical Commissioning Group (CCG) and national average. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to

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understand. Staff treated patients with kindness and respect, and maintained confidentiality. Support was available at the practice and externally for those suffering bereavement or that had caring responsibilities for others.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

The practice ran dedicated weekly long term medical condition clinics (LTMC). The practice had won awards in recognition of its integrated approach to long term conditions. The LTMC clinics were run weekly by a team of health care assistants, nurses and GPs all working together to ensure patients received a one stop medication and health condition review. The practice offered a care system to help patients self-monitor and manage their hypertension.

The practice had adapted its appointment system to meet the needs of patients. Data showed that there had been a 10% decrease in A&E attendance between 2013/2014 and 2014/2015 for patients over 75 years. Information highlighted the practice appointments system had helped reduce emergency admissions with cancer rates by 58% from 2010 to 2013 making this the 6th lowest cancer admission rate in the local. Telephone reviews were available for patients with hypertension, whose blood results were satisfactory. The practice website provided a link for patients to submit blood pressure readings to the GP from their home. Data showed the practice had consistently the lowest Trauma and Orthopaedics outpatient GP referral rates for all practices in the local.

Comments cards we reviewed and patients we spoke with, told us they could make an appointment with a named GP and that there was continuity of care, with emergency appointments available the same day. The practice had lift access to the first floor consultation and treatment rooms. The practice 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.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for well-led. The practice had a clear vision which had quality and safety 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 with evidence of team working 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. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and 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.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

The practice is rated as outstanding for the population group of older people. Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. The practice funded a gym and instructor to meet the needs of their elderly population and improve mobility and pain management. The practice provided support to local care homes, and patients who wished to remain in their own homes.

Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care. Data showed that there had been a 10% decrease in A&E attendance between 2013/2014 and 2014/2015 for patients over 75 years. The practice had also consistently the lowest Trauma and Orthopaedics Outpatient GP referral activity since 2013 in the local Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the population group of people with long term conditions.

The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. The practice provided regular health care reviews for patients with a range of long term conditions. The practice outcomes for childhood immunisations, cervical screening uptake and Quality Outcomes Framework were consistently above the local CCG averages. (The Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care.) There was support and education provided to patients with conditions such as diabetes, smoking cessation or obesity. The practice funded a gym and instructors to meet the needs of their patients with long term conditions and improve mobility and health management. The practice held regular multi-disciplinary team meetings to manage the care of patients nearing the end of their lives.

The practice set up a new approach to helping patients with hypertension. Patients were invited by the data team to attend the practice and to use the practice self-monitoring blood pressure machine, a protocol was followed by staff to ensure the GPs were

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aware of the patients latest readings and patients were updated of their next review. The focus on provision of information technology had increased both patient awareness and their ability to self-manage their condition. We saw this had an impact on treatment standards with the practice showing above local and national standards for the previous six years in hypertension treatment and monitoring. In 2013 the practice received a practice team award for sharing (in part) their methodology in managing patients with Hypertension. Data showed the practice appointments system had helped reduce emergency admissions with cancer rates by 58% from 2010 to 2013 making this the 6th lowest cancer admission rate in the local Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-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 high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Telephone on the day appointments were available and patients could specify when they would be available to speak with the GP. For example outside of school hours or during a coffee or lunch break. The premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Antenatal care was referred in a timely way to external healthcare professionals. Mothers we spoke with were very positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the population group of the working-age people (including those recently retired and students). The telephone appointment system gave patients the opportunity to specify when they were available to speak with the GP. Appointments were available from 8am Monday to Friday and there were extended hours pre-booked appointments until 12 midday on Saturday mornings. The needs of the local working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were

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accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion, support, counselling and screening at the practice which reflects the needs for this age group. The practice funded a gym and instructors to meet the needs of their patients; this was accessible after usual surgery hours for those patients who worked.

The practice focus on provision of information technology had increased both patient awareness and their ability to self-manage their conditions. Telephone reviews were available for patients with hypertension, whose blood results were satisfactory. The practice website provided a link for patients to submit blood pressure readings to the GP from their home. Data showed the practice had consistently the lowest Trauma and Orthopeadics outpatient GP referral rates for all practices in the local Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. In addition the lowest cancer admission rates for the area.

People whose circumstances may make them vulnerable

Good

The practice is rated as good. The practice was accessible for any vulnerable group. The practice had identified patients with learning disabilities and treated them appropriately. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation. The practice funded a gym and instructors to meet the needs of their patients to improve mobility and health management. The practice offered telephone consultations and contact via email. There was a booking in touch screen in the reception area with a variety of languages for people whose first language was not English. The practice used a telephone translation line to provide a confidential translation service to people whose first language was not English. A hearing loop was available for patients who had hearing impairments.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good. The practice was aware of the number of patients they had registered who had dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. 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 and

referred to other professionals for counselling and support according to their level of need. The practice funded a gym and instructors to meet the needs of their patients to improve mobility and health management.	

Summary of findings

What people who use the service say

The practice provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 27 comment cards, all the cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. Comments cards also included positive comments about the services available at the practice, appointment availability, the skills of the staff, the treatment provided by the GPs and nurses, the cleanliness of the practice, the support and helpfulness of the staff and the way staff listened to their needs. Patients recorded they were extremely happy with the care and treatment they received. These findings were also reflected during our conversations with patients during and after our inspection.

We spoke with four patients during our inspection. The feedback from patients was extremely positive. Patients told us about the ability to speak or see a GP on the day and where necessary get an appointment when it was convenient for them with the GP of their choice. We were given clear examples of effective communication between the practice and other services. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing, reception and the management teams were all very approachable and supportive. We were told they felt confident in their care and liked the continuity of care they received at the practice. The patients we spoke with told us they felt their treatment was professional and effective and they were very happy with the service provided. They told us things were clearly explained to them and clinicians gave them sufficient time during consultations and information to be able to make decisions about their treatment and care without feeling pressured. Patients told us that all the team were very supportive and that they thought the practice was very well run. Patients told us if they needed to complain they would speak to the reception team or the management team. We were told they felt their concerns would be listened to.

Patients told us they were happy with the supply of repeat prescriptions, with the access to the gym and the complimentary health services, such as osteopathy, reflexology and physiotherapy available at the practice. All the patients we spoke with commented this was an excellent practice and told us they would happily recommend the practice and its facilities to other patients.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for the security of blank prescription forms and improve the security of medicines waiting to be collected by patients.

Outstanding practice

- The practice provided a fully equipped gym with qualified fitness instructors to assist patients with improving their mobility, manage body weight and maintain a healthy lifestyle.
- The practice had responded to areas highlighted in the 2013 Patient Reference Group (PRG) survey, (this is a group of patients registered with the practice who have an interest in the service provided by the practice). These included inserting evacuation chairs in the stairwells, lowering sections of the reception

desk for wheelchair users and providing all clinical rooms with electric couches. Action had been taken to improve these areas including systems to review and improve the appointment system.

- The practice had a clear vision that was shared and owned by all staff. Structured policies and processes were followed to deliver high standards of care. Performance and governance arrangements were proactively reviewed. Leadership responsibilities were delegated appropriately and staff were able to demonstrate this worked well in practice.The clinical and management team shared decision making (both clinical and non-clinical) and worked effectively through clear communication and mutual support. There was a strong culture of shared learning, achievement and improvement to ensure that patients' needs were met.
- The practice had won awards in recognition of its integrated approach to long term medical conditions (LTMC). The LTMC clinics were run weekly by a team of health care assistants, nurses and GPs all working together to ensure patients received a one stop medication and health condition review.

Stowhealth

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Inspector.** The team included a GP specialist advisor, a practice manager specialist advisor, a medicines management inspector and a CQC observer.

Background to Stowhealth

Stowhealth Surgery provides primary medical services to approximately 17,859 patients and is situated in central Stowmarket, Suffolk. The practice provides services to a diverse population age group, in a semi-rural location.

The practice has a team of twelve GPs meeting patients' needs. Nine GPs are partners meaning they hold managerial and financial responsibility for the practice. There is a dispensary manager and seven dispensers. In addition, there are five nurse prescribers, two of which are nurse practitioners, three practice nurses, and five health care assistants, a business manager, a practice manager, a head of reception, and a team of medical secretaries, reception and administration staff. Stowhealth surgery is a training practice and GP registrars provide clinics throughout the year. Medical students also attended the practice for training. The practice provides a dispensary on site.

Stowhealth Surgery has implemented a total telephone triage system to manage demand for appointment bookings. The practice is open Monday to Friday from 8am to 6.30pm. Extended hours pre-bookable nurse and GP appointments are available on Saturday mornings 8.30am to 12 midday.

Patients using the practice had access to a range of other services, complimentary health services and visiting healthcare professionals. These included health visitors, midwives, dieticians, Improving Access to Psychological Services (IAPT), acupuncture, Counselling & Psychotherapy and weight maintenance advisors.

Outside of practice opening hours a service is provided by another health care provider, by patients dialling the national 111 service. Details of how to access emergency and non-emergency treatment and advice was available within the practice and on its website.

Why we carried out this inspection

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

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

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

Detailed findings

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)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 24 February 2015. During our inspection we spoke with a range of staff including GP partners, practice nurses, health care assistants, dispensary staff, reception and administrative staff and the practice management team. We spoke with patients who used the service and visiting health care professionals. We observed how people were being cared for and talked with carers and family members and reviewed personal care or treatment records of patients. We reviewed 27 comment cards where patients and members of the public shared their views and experiences of the service.

We looked at records and documents in relation to staff training and recruitment. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety including incidents, comments, complaints and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts contained safety and risk information regarding medication and equipment, often resulting in the withdrawal of medicines from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. From the minutes of practice meetings, the practice intranet, communicated emails to staff and through discussion with staff we saw that information was shared with staff so as to improve patient safety. Complaints, accidents and other incidents such as significant events were reviewed regularly and discussed at practice meetings to monitor the practice's safety record and to take action to improve on this where appropriate.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Through discussions with staff and a review of records we saw that significant events, accidents,

and other safety incidents were fully investigated. An analysis was carried out to determine where improvements could be made and to identify learning opportunities and prevent recurrences. We saw that incidents and significant events were discussed with staff at regular meetings and on an individual basis as

needed. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of learning outcomes. There was evidence that the practice had learned from these and that the findings were shared with relevant staff and where appropriate other services. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

Staff we spoke with told us that the practice had an open and transparent culture for dealing with incidents when things went wrong or when there were near misses. They told us they were supported and encouraged to raise concern and to report any areas where they felt patient care could be improved. Staff, including receptionists, secretarial, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. For example staff told us how they would contact the relevant agencies should they have a concern and notify the duty GP and the safeguarding GP lead.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

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 or patients with a diagnosis of dementia or those requiring additional support from a carer. There were systems in place to follow up children who persistently failed to attend appointments, such as childhood immunisations.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. There were designated reception staff who would act as a chaperone if nursing staff were not available. These staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

There were system in place for reviewing repeat medications for patients with co-morbidities/multiple medications. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary itself was well organised and operated with adequate staffing levels.

The dispensary manager told us that members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly, but we found that the process for recording this wasn't followed consistently.

There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. We saw that procedures were updated regularly, and records showed that staff had read the procedures relevant to their work. There were arrangements in place to record and follow up medicine related incidents and drug safety alerts.

The dispensary provided a weekly medicines delivery service to housebound patients. Patients were offered a choice of methods for requesting repeat prescriptions. Staff identified in advance when patients were due for a review or needed blood tests before the next prescription was issued, and contacted patients to remind them.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw that this process was working in practice. We found that there were arrangements for the secure storage of blank prescription forms. However record-keeping practices were not in line with national guidance and we could not be assured that if prescriptions were lost or stolen this could be promptly identified and investigated.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. We checked a sample of controlled drugs and found we could account for them in line with registered records.

Completed prescriptions were handed out from a shop in the entrance hall, separate from the dispensary. We observed that staff followed safe procedures for checking patients' identity and that confidentiality was maintained. We were not assured that the practice had assessed the security of the storage arrangements here, and there was therefore a risk that medicines could be accessed by people they were not prescribed for.

Good

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last four years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example when handling a sample or clearing up spillages. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap, sanitising gel and paper towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the recent findings from a room by

Good

Are services safe?

room infection control audit were shared with the teams. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

A business continuity plan was in place to deal with a range of emergencies that 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 telephone company to contact if the telephone system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw examples of the risk analysis of the appointment systems, information governance, the practice finance and accounting, physical access for patients and health and safe assessments and the mitigating actions that had been put in place to manage these.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Information and new guidance were made available in information folders on the electronic system and were shared with staff during regular meetings to ensure that practices were in line with current guidelines to deliver safe patient care and treatments. 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 employed two nurse practitioners who were qualified to provide diagnostic consultations for patients with minor illnesses and injuries. They were also able to prescribe medicines without the need to refer the patient to a GP. This meant that patients with more complex needs could see a GP. The nurses also undertook child immunisations and cervical smear testing.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. One GP with an interest in diabetes was responsible for initiating insulin therapy at practice level. Clinical staff we spoke with told us about the daily clinical meetings/coffee breaks where issues and concerns could be addressed with colleagues, we saw that staff were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. We saw that this also took place during clinical meeting and the minutes we reviewed confirmed that this happened.

One GP partner showed us data from the local CCG of the practice's performance for prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. 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.

The practice dispensary worked with the CCG to review their prescribing to achieve value for money. This identified whether the practice was using the most cost effective medicines. The practice had a system in place to assess the quality of the dispensing process and was part of the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Regular liaison took place and the practice was informed when a more cost effective version of a particular medicine was available and they were able to change their ordering process accordingly.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the business manager and practice manager to support the practice to carry out clinical audits.

We saw eight clinical audits that had been undertaken in the last 12 months. We looked in detail at three of these audits which were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice looked in detail at patients with chronic obstructive pulmonary disease (COPD) who had been admitted to hospital during an 18 month period. The aim of this audit was to prevent readmissions for these vulnerable patients. Following the audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved and were maintained. For example where appropriate patients were referred to the COPD outreach team, patients at diagnosis would be given clear

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Are services effective?

(for example, treatment is effective)

advice and guidance regarding the action they should take during exacerbation of their condition and those patients who had not received regular medication or health check reviews would be encouraged to attend for review where the advice and guidance would be reinforced.

Other examples included audits of antibiotic prescribing across the clinicians at the practice. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Following the audits, the GPs carried out medication reviews for patients who were prescribed these medicines and where appropriate altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example the 2013/2014 QOF results showed 98.7% of patients with diabetes had an annual medication review. The practice had met the maximum standards for QOF in 2013/2014 for asthma, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease (lung disease), dementia and depression among others.

GPs attended regular practice referral meetings. These provided a referral management strategy that was built around peer review and audit and was supported by consultant feedback.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

General blood test results were reviewed by a GP each day and those requiring action were sent to the relevant member of staff for action. For example to reception if the patient required an further appointment. Time was allocated for this purpose to ensure these were carried out.

The practice had a palliative care register for those patients that required end of life care. Regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families took place, although the practice told us that district nurse resources did not always allow this to be as regular as they would have liked. They described a good relationship with Macmillan nurses, the hospice nurse and consultants.

Effective staffing

The practice employed staff who were skilled and qualified to perform their roles. Appropriate checks had been made on new staff to ensure they were suitable for a role in healthcare. We looked at employment files, appraisals and training records for a cross section of staff members. We saw evidence that staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw that staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration. Staff we spoke with told us that the practice provided opportunities for learning and that they undertook a range of online and face-to-face training.

All new staff underwent a period of induction to the practice. Support was available to all new staff to help them settle into their role and to familiarise themselves with relevant policies, procedures and practices.

Good

Are services effective?

(for example, treatment is effective)

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

Individual staff performance was assessed and training and development needs were identified through an annual appraisal system. Staff had personal development plans that detailed their planned learning and development objectives, which were kept under review. We saw that where staff had identified training interests arrangements had been made to provide suitable courses and opportunities. The practice team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff spoke positively about the culture in the practice and the support that they received. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had dedicated leads for overseeing areas such as safeguarding, palliative care and learning disabilities. The practice nurses had undertaken specific training in health promotion and the treatment of minor illness such as, acute asthma, smoking cessation and sexual health

Stowhealth took part in teaching medical students from the University of East Anglia. In addition to this the practice provided placements to F2 Doctors (these are second year foundation medical graduates, where doctors learn about working in the teams that deliver care in the NHS as well as the clinical aspects of caring for sick patients) and GP registrars who are in the final stages of completing their qualifications. GP registrars training to be GPs were offered extended appointments and had access to one of the partner GPs throughout the day for support. Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical screening. Those with extended roles for example in conducting diabetic examination were also able to demonstrate that they had appropriate training on the Warwick Course to fulfil these roles.

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

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 local care homes which provided support for elderly patients. Representatives of the homes described the support provided to the staff and patients by the GPs. The practice provided homes with a carers edition booklet on Supporting the Use of Medication in the Care Setting. This set out detailed directions and advice on the administration of liquid, inhaled and oral medicines, the administration of topical medicines, storage of medicines and other information necessary in the support of safe medicine administration in the care setting. Such as the safest method to administer calcium supplements and what to avoid, for example carbonated drinks.

It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

We also saw how the practice spoke with and worked collaboratively with hospitals and consultants to the benefit of its patients. The practice provided designated rooms within the building for hospital outreach services and complementary therapists such as acupuncture, allergy therapists, aroma therapists, counselling and psychotherapy, physiotherapy and reflexology. There were also Audiology and Improving Access to Psychological Therapies (IAPT) services available for patients at the practice.

There were regular meetings, involving other different professionals, to discuss specific patients' needs. For example patients with end of life care needs, and children

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Are services effective?

(for example, treatment is effective)

at risk. These meetings were attended by district nurses, social workers and palliative care nurses. The practice provided a designated room for the midwifery group attached to the practice. These specialist nurses looked after the practice ante-natal patients and undertook visits to mothers and babies following delivery. The midwives were able to access the practice computer system and liaise directly, either via the computer system or as a one to one meeting, with the GPs and nursing team.

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

Electronic systems were also in place for making referrals through the Choose and Book system. 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.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Patients were supported to choose the hospital/specialist of their choice when there was a need to refer them for specialist treatment. This preference was then sent to a central referral point where the most appropriate clinical pathway was selected and the patient advised of the date of their appointment. We were told that referrals were dealt with within 24 – 48 hours. We saw that the practice had a tracking system in place which showed us that there was no backlog and patients usually received the date of their appointment within two weeks of the referral.

The practice received information from the local GP out-of hour's service when their patients had cause to use it. The record of the consultation was then placed on their electronic system and reviewed by the GP to assess whether a follow-up appointment was required.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. Staff showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

We found that staff were aware 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. We saw that 76.8% of patients on the practice learning disability register had received a health check and had their care plans reviewed within the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a consent policy for staff to refer to that explained the different types of consent that could be given. For example, for all minor surgical procedures, the completion of a consent form was required. This covered the understanding of the procedure and any risks involved with it. Staff were aware of the different types of consent, including implied, verbal and written. Nursing staff administering vaccinations to children were careful to

ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent. We were told where there was doubt the procedure was delayed until the consent issue could be clarified.

The practice had undertaken an audit of consent given and recorded in the clinical records for all minor surgery procedures performed between 1 October 2014 and 31 December 2014. We were told that of the 51 procedures undertaken during that period, one procedure had not been correctly recorded on the clinical records. The business manager told us that as a result of this audit, a reminder was sent to all clinicians to properly complete the minor surgery template in full for future procedures.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

There was a wide range of information leaflets, booklets and posters about health promotion and healthy lifestyle choices available within the waiting rooms, reception and entrance hall where patients could see and access them and on the practice website. This included information on safeguarding vulnerable adults and children and about services to support patients, such as weight loss advice and smoking cessation advice We saw information about mental health, domestic abuse advice and support was prominently displayed in waiting areas with helpline numbers and service details. There was information and guidance available on diet, smoking cessation and alcohol consumption. There was information available about the local and national help, support and advice services. This information was available in written formats within the practice. Large print documents and information in languages other than English were available if needed.

We looked at the New Patient's Registration pack; this included a patient confidential questionnaire which requested information about the patients' medical history, medication, lifestyle and family history, for example smoking and alcohol consumption. An introduction to Stowhealth booklet, which detailed information on the practice opening hours, the staff, appointment times, the practice website, dispensary and other services available such as the various health clinics, Art/Health promotions available and the complimentary therapists available at the practice, the health retail shop and the gym and personal trainers available at the practice. The leaflet also detailed information on the practice complaints procedure and GP and medical student training that took place at the practice. Information on the NHS Summary Care Record and Care Data was also included. In addition the pack included a diverse variety of useful contact information for patients living in the Stowmarket area for services such as Age UK, Alzheimer's Society, Citizens Advice, day centres and emergency dental services. In addition it provided patients new to the area local information such as contact numbers for gas escapes contact numbers, Suffolk Family Carers and talking books.

All newly registered patients were offered routine medical telephone appointments with their named GP. This was followed up by a healthcare assistant, nurse or GP as appropriate. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic health and smoking cessation advice to patients who smoked. Patients between 40 and 75 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check. Nurse led clinics and pre-booked appointments were available including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma clinics.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

The practice identified patients requiring additional support. The practice offered signposting for patients, their families and carers to a range of organisations such as Help the Aged and Suffolk Family Carers. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. These patients attended the practice for their annual review of their condition. Care plans in place were the subject of regular reviews. The computerised record system was used to

Good

Are services effective?

(for example, treatment is effective)

identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears.

The practice provided patients and staff with a fully equipped gym. This equipment included a number of cardiovascular machines and various forms of resistance tools and weights and was used in conjunction with the qualified gym instructors to support patients in improving their mobility, manage body weight and maintain a healthy lifestyle

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National Patient GP survey, a survey of 228 patients undertaken by the practice's patient reference group (PRG) in 2013/2014 and a variety of patient satisfaction questionnaires sent out to patients by the practice. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey sent 262 surveys to patients, there had been a 46% response rate. Results showed the practice was rated 'among the best' at 89% for patients who rated the practice as good or very good in comparison to the CCG average of 86%. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them, 92% saying the nurse was good at listening to them, 87% saying the GP gave them enough time and with 95% saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 27 completed cards and they were all very positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were caring, efficient, friendly and professional. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

The practice had a range of anti-discrimination policies and procedures and staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the business or practice manager. The business manager and practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patients' consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The results from the 2014 National Patient GP survey which we reviewed showed that patient's' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 91% of practice respondents said the GP was good at explaining treatment and results and 89% that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that the GPs were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the

comment cards we received was also overwhelmingly positive and each of the four patients we spoke with told us that they were happy with their involvement in their care and treatment.

Staff told us that the vast majority of patients registered with the practice were English speaking. They told us that translation services would be made available for patients who did not have English as a first language. An electronic appointment check-in system, was available to reflect the most common languages in the area. Staff had access to an interpretation and translation service.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 81% of respondents to the 2014 National Patient GP survey said the GPs were good at treating them with care and concern and 94% said the last nurse they saw was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice identified vulnerable patients and kept a register. The practice monitored the emergency

admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. This monitoring identified patients most likely to have an unplanned admission to hospital. Where patients were identified as vulnerable, care plans were implemented, which were discussed and reviewed at multidisciplinary team meetings to help ensure that patients had appropriate support systems in place to help reduced unplanned admissions to hospital.

Notices in the patient waiting room, on the TV screen, in the new patient registration pack and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation when required and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 had sustainable systems in place to maintain the level of service provided. We found that the practice understood the needs of the patients using the service and the services were tailored to patients' needs to ensure flexibility, choice and continuity of care. The practice held information about the prevalence of specific diseases, this reflected the level of service provided. For example, reviews of patients with long term conditions, cervical screening programmes, flu and pneumococcal vaccinations and childhood immunisations. There were systems in place to contact patients who failed to attend for screening programmes and immunisations. Patients were invited for attend for health checks and flu vaccinations. Where patients had provided a mobile telephone number the practice notified them by text message. We were told that where this was used to remind patients of their appointment this had reduced the number of patients who did not attend an appointment. Where patients were unable to attend the practice due to immobility or their condition a home visit was arranged.

The practice ran dedicated weekly long term medical condition clinics (LTMC). After consultation with a group of patients, the clinics were set up to reduce the need for patients to make multiple visits to the practice to see the practice nurse and the GP. The practice had won awards in recognition of its integrated approach to long term conditions. The LTMC clinics enabled the practice to recall patients with long term conditions (asthma, diabetes, stroke, hypertension, heart disease and chronic obstructive pulmonary disease (COPD) in a more efficient way. The LTMC clinics were run weekly by a team of health care assistants, nurses and GPs all working together to ensure patients received a one stop medication and health condition review. The NHS Local Area Team (LAT) and Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. For example by sharing the LTMC plan with local practices.

In 2012, the practice set up a new approach to help patients with hypertension. Patients were invited by the data team to attend the practice and to use the practice self-monitoring blood pressure machine. Staff then followed a protocol to ensure the GPs were aware of the patients latest readings and patients were updated of their next review. Telephone reviews were available for patients with hypertension, whose blood results were satisfactory. The practice website also provided a link for patients to submit blood pressure readings to the GP from their home. We saw that the focus on provision of information technology had increased both patient awareness and their ability to self-manage their condition. We saw this had an impact on treatment standards with the practice showing above local and national standards for the previous six years in hypertension treatment and monitoring. In 2013 the practice received a practice team award for sharing (in part) their methodology in managing patients with Hypertension.

Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. Data showed that there had been a 10% decrease in A&E attendance between 2013/2014 and 2014/2015 for patients over 75 years. The practice had also consistently the lowest Trauma and Orthopaedics Outpatient GP referral activity since 2013 in the local Clinical Commissioning Group (CCG). CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Other patients could request to see a GP of their choice and this was accommodated on most occasions. Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of ten minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us they did not feel rushed during their appointment, that the GPs listened and understood their concerns, explained things to them and gave them the time they needed.

The appointment system meant that although patients could always see a GP when required, the appointment may not always with their preferred GP. The appointment system was effective for the various population groups that

attended the practice. Patients told us that they rarely had to wait until the next day to obtain an urgent or routine appointment and they were very complimentary about the speed at being able to see a GP or the nurse. Data showed the practice appointments system had helped reduce emergency admissions rates with cancer by 58% from 2010 to 2013 making this the 6th lowest cancer admission rate in the local CCG.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours, but patients we spoke with told us that they were often ready for collection earlier.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Such as reviews of the appointment systems, installation of air conditioning units in the practice waiting rooms and reception area and customer service training for all staff at the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. All the treatment and consultation rooms were situated on the first floor, however where patients were unable to access the lift or stairs there were treatment rooms available on the ground floor. There were accessible toilets and baby changing facilities available. The practice had access to a telephone translation service.

The appointment check-in facility in the practice was set up to reflect the most common languages in Stowmarket. Equality and diversity training had been provided to staff. Staff were knowledgeable about language issues and described how they would access an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. We saw evidence of staff supporting people who were unable to use the booking in screen or read the appointment information monitor in the reception area.

Patients who were homeless were able to use the practice's address to register as a temporary patient.

Access to the service

The practice told us they took being responsive to patient needs seriously and ran a total telephone appointment system. Appointments were available daily from Monday to Friday in the morning and afternoons. Patients could also register to book telephone consultations on-line. To support this service the practice nurses ran minor illness clinics which the GPs could book their patients into. We were told and we saw that patients were offered an on-the-day appointment where necessary. This system provided more doctor patient 'over the telephone' consultations which in some cases meant the patient did not need to attend the practice. Patients telephoned the practice and were asked for brief information about why they needed to see a GP; a GP would then telephone the patient back. Where patients were unable to take a call due to work or family commitments they could specify a convenient time for the GP to call. The GP would then schedule a call for example during the patients coffee or lunch break or when home from the school run. Where a telephone consultation was not sufficient, an appointment was then offered for the same day or where required the GPs would book the patient into an advanced appointment. The GP would determine the length of the appointment according to the patients' needs. Patients did not have to telephone the practice before a certain time in order to access an 'on the day' appointments. All calls made throughout the day were actioned in the same way or referred to the duty GP.

In addition to the practice being open from 8 am to 6.30pm Monday to Friday, the practice also offered extended hours pre-booked nurse and GP appointments on Saturday mornings from 8.30am to 12 midday.

The practice provided on line services which meant patients could pre book telephone consultations appointments and order repeat prescriptions online. Where patients had provided a mobile telephone number the practice provided a text service to confirm when their appointment or telephone consultation would be. There was an informative practice website with information about the practice, the services that were offered by the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice and links to other organisations and interactive tools such as fitness and interactive health tools such as tips for health living and the practice video library giving advice on conditions such as diabetes and kidney disease.

The practice gave priority to patients with emergencies and to children. They were seen on the same day where necessary. Patients could select their GP of choice if they were available. Chaperones were readily available for patients to use on request. We saw how staff supported patients who were vulnerable or homeless when they attended the practice. Staff offered guidance and advice to patients during their visit to the practice and were quick to respond to patients or visitors who needed support.

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed during their consultation.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Patients were very satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had regularly been able to make appointments on the same day of contacting the practice.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice was fully accessible to people with disabilities. There was a passenger lift to all floors within the practice, and all consultation rooms were accessible though wide corridors.

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

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

Patients we spoke with had not had any cause for complaint. We saw that complaints recorded in the last 12 months had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice. 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. How the practice were made aware of the complaint was also recorded, and we saw that any verbal indications of dissatisfaction were investigated. We looked at the most recent complaints the

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

practice had investigated. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place to ensure learning as a result of complaints received was disseminated to staff.

Patients' comments made on the NHS Choices website were monitored. These were discussed at practice meetings and where changes could be made to improve the service these were put in place.

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 personal health care of a high quality and to seek continuous improvement on the health status of the practice population. We saw the practice three year and 12 month business plans that were in place, and saw the practice's vision and values were included in the documents. We also saw the Executive Boards work plan which detailed the individual work streams, their progress to date and the outcomes and key dates for completion. For example implementing transformation projects such as practice nurse support to housebound patients and medication wastage, we saw both projects had been completed. The medication wastage project included implementation of the carer handbook and delivery of workshops to local care services. The practice aims and objectives were made clear in their statement of purpose and these included developing and maintaining a happy, sound practice responsive to patient needs and expectations and which reflected where possible the latest advances in Primary Health Care. These values were evident during our inspection from meeting and talking with patients and staff.

The GPs and management team had a clear vision and purpose to deliver high quality medical care to its patients in a friendly and professional manner. The GPs we spoke with were able to demonstrate a clear understanding of their role and responsibility within the practice. We saw that all staff took an active role in ensuring provision of a high level of service on a daily basis. There was a defined structure and each department had a manager or supervising head who reported to the business manager and practice manager and to the partners on certain clinical issues. Staff spoken with were clearly aware of the direction of the practice and were working towards it. Staff job descriptions and appraisals supported the direction in which the practice wished to head and they were clearly linked to the vision and objectives of the partnership. Staff told us they felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance arrangements

There was an executive board and management team in place to oversee the systems at the practice, ensuring they were consistent and effective. The management team covered all aspects run by the practice. The management team were responsible for making sure policies and procedures were up to date and staff received training appropriate to their role. We saw evidence that feedback from patients was discussed at the weekly staff meetings and learning was applied. The executive board and management team also met on a regular basis.

There was a very clear leadership structure within the executive board and management team. This included the partners, the business manager, the practice manager, the dispensing manager and team leaders such as the lead nurse and head of reception. Designated leads included infection control, chronic disease management such as asthma, pharmacy shop, dispensing, safeguarding, information technology (IT), complaint handling, and health and safety. Staff we spoke with were aware of the various leads and knew who to discuss issues with if the need arose. The management team and GP Partners took an active role in overseeing all systems in place at the practice to ensure they were consistent, safe and effective.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. This is an annual incentive programme designed to reward good practice. The QOF data for this practice showed the practice had achieved 98.5% for the year 2013 to 2014 this showed the practice was performing above local and national average at 10.1 points above the local CCG average and 5 points above national average. We saw that QOF data was reviewed each month to ensure that health targets were being achieved. This was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice undertook a range of audits that monitored the quality of the services they provided. These included clinical audits, referral audits, prescribing medicines, cleaning, appointment availability and infection control audits.

The practice had robust arrangements for identifying, recording and managing health and safety risks. These were clearly identified and reviewed on a daily basis to ensure that patients and staff were safe. The practice secretary was able to demonstrate on the electronic system that all results, reports, discharge summaries and out-patient letters were dealt with within 48 hours and any urgent ones were brought to the immediate attention of the duty GP.

Are services well-led?

Outstanding ☆

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

There were a number of regular meetings scheduled and held throughout the year. There were also a number of individual team and full practice meetings. Meetings were held for both business and educational purposes and covered the wide range of clinical services provided by the practice. In addition meetings were multi-disciplinary and the practice therefore regularly liaised with a range of professionals from the wider healthcare community. We saw the minutes of four recent clinical meetings. The meetings followed a regular agenda and patient feedback, clinical cases and safeguarding were always discussed. The practice regularly submitted governance and performance data to the Clinical Commissioning Group (CCG). The GPs and practice manager attended neighbourhood and Clinical Commissioning Group (CCG) meetings to identify needs within the local community and tailor the practices services to meet these needs. The Executive board and management team produced an annual work plan performance report

This gave in-depth information about the progress of business objectives agreed by the board. These objectives included improving the quality of essential services, providing preventative health services, the progress of research studies the practice took part in, staff training initiatives and requirements, and providing outreach services from the practice.

We saw that team meetings were used to discuss issues and improve practices. There was evidence that feedback from patients was discussed with staff and learning outcomes were implemented.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control. The senior partner was the team lead for critical event and significant event reviews. The members of staff we spoke with were all clear about their own roles and responsibilities.

We saw from the minutes we looked at that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Where staff were absent for any reason they were provided with minutes of the meetings to enable them to remain up to date. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was a low turnover of staff.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place that included the induction policy and job descriptions which were in place to support staff. The staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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. 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.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice carried out annual surveys to seek feedback from patients. The results of each survey had been analysed to identify areas for improvement and these had been actioned wherever possible. We saw that from the last GP patient survey in 2014 that patient satisfaction was high. Of 262 surveys sent out 121 responses were received. 89% of respondents to the national GP survey described their overall experience as good, as compared to the CCG average of 86% and 88% responded they would recommend the practice to someone new to the area. 99.6% of respondents to the 2013/2014 patient reference group described their overall experience of the practice as fair, good, very good or excellent. The practice leaflet and website invited feedback from patients and carers. The practice manager told us this feedback was used to review and improve the services provided.

Are services well-led?

Outstanding ☆

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

The practice had a Patient Reference Group (PRG), (this is a group of patients registered with the practice who have an interest in the service provided by the practice) we were told the group had 17 members. Areas highlighted and actioned from the PRG 2014/2015 patient survey included; inserting evacuation chairs in the stairwells, lowering sections of the reception desk for wheelchair users, providing all clinical rooms with electric couches. We saw that action had been taken to improve these areas including systems to improve car parking facilities, improvements to patient information and self-led care, and practice and patient reference group engagement with Health Watch Suffolk to improve patient engagement and experience.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

The practice management operated on a corporate basis with an appointed executive committee responsible for daily decision making and strategic planning on behalf of the partnership. The business manager and practice manager worked closely with the two representative GP partners.

The practice had developed learning plans for each member of the clinical team. We viewed records that demonstrated effective annual appraisal processes had been in place for a number of years as well as six monthly reviews which supported staff education and development. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We were told that the practice was very supportive of training. Staff files reflected that training had been identified and provided to staff to enable them to meet the needs of the patients. Whole practice events were organised that enabled staff to participate in training and personal development. We were told these gave staff the opportunity to discuss proposed changes. The staff files we examined provided evidence that training was up to date and staff had attended appraisal meetings with their line manager. We also saw that new staff followed a formal induction programme where they received regular feedback and were in turn asked for their opinion of how their induction programme was being managed.

The practice was a GP teaching practice aligned to The University of East Anglia. Staff told us how they valued the opportunity to teach and learn from the students regarding new medical developments. The GPs found it challenging and enjoyable, presenting staff with an opportunity to keep their skills and knowledge current. GPs had interests in primary mental health care, GP appraisals, medical student training, commissioning and clinical research. One GP with an interest in diabetes was responsible for initiating insulin therapy at practice level, another GP was the chair for the Ipswich and East Suffolk CCG.

In 2006, one GP Partner attended the House of Lords to receive the Guy Rotherham award for their work in developing the Long Term Medical Conditions (LTMC) clinics operating at the practice.

In 2013 the practice was awarded the RCGP Practice team of the year award and in 2014 the practice was awarded the General Practice Awards General Practice Team of the Year Award. The business manager and practice manager were also active members of the Suffolk Brett Stour Managers group and attended regular meetings to network with other practice managers and the Local Medical Committee.

The practice had strong relationships with the community teams including the district nurses, health visitors, community matron, midwives, and the community mental health teams.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. Audit outcomes, the results of a patient surveys, patient feedback and the analysis of significant events and complaints were used to improve the quality of services. Where audits had taken place these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.