

Clements & Kedington Surgery

Inspection report

Clements Surgery
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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 location

Requires improvement



Are services safe?

Good



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Good



Overall summary

This is the first inspection of Clements & Kedington Surgery practice under the provider of The Suffolk Federation. We had inspected the practice under the previous provider in December 2014 and the practice was rated as good. The Suffolk Federation took over the practice in July 2017.

The practice is rated as Requires Improvement overall.

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? - Good

We carried out an announced comprehensive inspection at Clements and Kedington Surgery on 9 August 2018 as part of our inspection programme.

At this inspection we found:

- The practice had been taken over by the Suffolk Federation which was a not for profit health organisation.
- The practice had seen a significant number of clinical and non-clinical staff leave the practice and experienced difficulties in recruiting GPs. However, they reviewed the skill mix required and had been successful in recruiting other staff.
- The practice used a wide range of comprehensive risk assessments to ensure issues were identified, mitigated, improvements made and monitored effectively. These were translated into detailed action plans which were monitored regularly by the practice management but also by the Federation board. For example, a backlog of medicines reviews had been identified and clinical resources were allocated to address the issue.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.

- Due to staff shortages the practice recognised that the Quality and Outcome framework performance for 2017/2018 had reduced in some indicators and their performance was lower than the 2016/2017 data that relates to the previous provider. We saw that an action plan was in place along with additional clinics as they aimed to improve patient outcomes.
- The practice had implemented a new telephone and appointment system in May 2018. Patients we spoke with told us they found the appointment system easy to use and reported that they could access care when they needed it.
- The practice had experienced poor patient satisfaction but changes they had made had resulted in lower complaints and more positive comments and improved staff morale however the new systems had only been in place since May 2018 and the management team had not had the opportunity to fully evaluate them to ensure they could be sustained and were effective to improve patient satisfaction.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to review and monitor the actions plans in place relating to security, medicine reviews, and staff immunisations to mitigate identified risks, sustain and make further improvements.
- Monitor and improve the practice performance and practice improvement plan in relation to the quality and outcome framework and ensure that all patients receive their annual reviews in a timely manner in particular to those relating to long term conditions including those affecting older people.
- Monitor the National Patient Survey data and continue to make changes and monitor the impact of those changes to improve the experience of patients in relation to access to the practice and monitor the impact of those.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser, a practice nurse specialist adviser, and a member of the CQC medicines team.

Background to Clements & Kedington Surgery

Clements and Kedington Surgery is in the NHS West Suffolk Clinical Commissioning Group (CCG) area. The practice is situated in the town of Haverhill and is contracted to provide general medical services to approximately 17,350 registered patients. The practice operates from the main location at Clements Surgery, Greenfields Way, Haverhill and from the branch site at Christmas Maltings Surgery, Camps Road, Haverhill, and there is also a branch surgery at Kedington Surgery, 36 School Road, Kedington, Suffolk. We visited the main location at Clements Surgery and the branch site Christmas Maltings Surgery. The practice dispenses medicines from the Christmas Maltings site to those patients who live more than one mile (1.6km) from the nearest pharmacy.

Suffolk GP Federation took over the management of the practice in July 2017.

There are seven salaried/regular locum GPs (four female and three male). Three are salaried GPs who provide the clinical leadership for the practice. The practice has four practice nurses including a lead nurse and two emergency care practitioners (male). There are three advance nurse practitioners (employed and locum), two physician associates and three health care assistants. A number of administrative staff support the clinical team

including a practice manager, receptionists and administrators. There is a team of dispensing staff including a dispensary manager who work with the pharmacists.

The practice is open between 8am and 6.30pm on Mondays to Friday and the small Kedington branch is open between 11am and 12pm for dispensary services and clinics are held but not at regular times. Patients are given the information at the time of booking and posters are put on the door. Patients who prefer to be seen at the small branch have found this useful.

The practice is working with other practices as part of the GP+ service to offer appointments to patients at various sites until 8pm in the evening and at the weekend.

Outside of practice opening hours, patients are directed to the local out of hours service provide by Integrated Care 24 (IC24) through NHS 111.

According to Public Health England information, the patient population has a slightly higher than average percentage of patients aged under 18 and slightly lower percentage of patients aged 85 or over, compared with practice average across England. Income deprivation affecting children and older people is significantly lower compared to the practice average across England.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. We saw evidence of several safeguarding concerns that had been well managed and information shared appropriately.
- Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The practice had a contract with a Suffolk GP Federation's own prescribing support service, with pharmacists available to carry out medicines reviews, update prescriptions in line with advice from consultants and advise practice staff on prescribing.
- There was an effective induction system for temporary staff tailored to their role.

- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The practice population had a culture of arriving at the practice without an appointment booked, the practice accommodated this and ensured staffing resources were available to manage the queue. The patients and staff we spoke with told us of emergencies that had been well managed with good outcomes for the patients and relatives.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines. Since taking over the practice, the management team

Are services safe?

had identified a significant number of patients had not been followed up appropriately and in a timely manner, they allocated additional clinical staff to address the issue.

- Arrangements for dispensing medicines at the practice kept patients safe although access improvements to the area where medicines, including controlled drugs, had not been finalised.
- There was a written procedure for the provision of weekly blister packs, but it did not include guidance on identifying whether products were suitable for inclusion in this type of pack. The practice took immediate action to rectify this.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues and detailed action plans and these were monitored regularly.

- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were clear and effective systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice and the population groups of older people and long term conditions as requires improvement for providing effective services. We rated the population groups of families, children and young people, working age people (including those recently retired and students) and people experiencing poor mental health (including people with dementia) as good for providing effective services.

We rated the practice and the population groups of older people and long-term conditions as requires improvement for providing effective services overall because;

The quality and outcome framework data used in the evidence table relates to the previous provider, the practice took over the practice in July 2017, and shared with us their performance data for 2017/2018 which showed the practice over performance had decreased in areas relating to long term conditions and indicators that usually effects older people such as COPD.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions in the records we viewed.
- The data used in this evidence table related to the year 2016/2017. The practice had taken over the practice in July 2017 and during the first six months of their take over the practice had a significant shortage of all staff including clinical staff. The practice shared their data for 2017/2018 and this showed that the practice scored 83% of the available points overall; this had decreased from 95% in the previous year when the practice was managed by a different Provider. Following a review of the practice performance for 2017/2018 data which was unverified, the practice implemented an action plan and changes had been implemented, however the success of these improvements had not been evidenced yet. The practice had a recall system in place with an administrator who had complete oversight of the recall

system and the performance was discussed at the monthly meeting where clinical and non-clinical staff attended. The practice had introduced an electronic template system ensuring all monitoring was undertaken and information recorded correctly.

- The practice provided blood pressure monitoring machines in the waiting area giving patients easy access to managing their condition. The information was added to the clinical records and the GPs were informed of any concerns. The practice was encouraging patients to use this to help address the lower performance figures achieved in their 2017/2018 data and to ensure the patients were monitored appropriately.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a medicine review.
- The practice performance in relation to some QOF indicators had decreased for example; The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months had decreased from 95% in 2016/2017 to 53% in 2017/2018.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less had decreased from 80% in 2016/2017 to 59% in 2017/2018.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The pharmacists contacted patients if there was any change to their medicines to ensure they had adequate supplies and understood how to take them.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

Are services effective?

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The practice performance in relation to some indicators in QOF had decreased for example; The practice overall performance in relation to diabetes indicators was 93% in 2016/2017 this had decreased to 47% in 2017/2018.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Home visits were undertaken for older patients or who were unable to attend the practice.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90% with a range from 89% to 97%. The practice was aware of the results that were below the 90% and the practice nurses and health visitors contacted the parents or guardians to discuss the programme and encourage uptake.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 69%, which was below the CCG average of 75% and the national average of 72% and below the 80% coverage target for the national screening programme. The practice had reviewed their lower performance in relation to the national screening programme. Additional clinics in the evening and on Saturdays had

been introduced to improve access. The practice sent reminders to patients using pink letter paper to highlight the importance. Pictorial and other types of communications were used to reach those patients who may find usual correspondence harder to understand.

- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had clear oversight of the management of patients who may have a learning disability and we saw examples of where staff had ensured effective care by using pictorial information such as cervical screening.
- The practice had undertaken a review of vulnerable patients and had recognised the number of times patients presented at the practice. They were working with a nurse practitioner to look at a different and dedicated pathway for these patients to access the help they needed.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medicines.

Are services effective?

- The practice had increased their performance for the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) had increased from 71% to 100% in the unverified QOF data 2017/2018.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The practices had recognised that the patients who needed specialist mental health services had to travel a significant distance to Bury St Edmunds and Ipswich. The Suffolk Federation were working with other agencies to bring services to Haverhill including employed nurses who specialised in mental health conditions.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- The data used in the evidence table related to the year 2016/2017. The practice had taken over the practice in July 2017 and during the first six months of their takeover the practice had a significant shortage of all staff including clinical staff. The practice shared their data for 2017/2018 and this showed the practice performance was 83% compared to 95% in the previous year. The practice had increased performance in some indicators for example, the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) had increased from 71% to 100%.
- The practice had been successful in the past six months recruiting permanent staff. They now had a wide skill mix including GPs, advance nurse practitioners, emergency care practitioners, pharmacists and physician associates. They shared with us their action plan to further improve their performance in the coming

year which detailed the additional resources, clinics and use of the GP+ hub to ensure easy access for patients to attend their reviews. The practice held regular monthly meetings to monitor performance.

- The practice exception reporting was in line with the CCG average.
- The practice used information about care and treatment to make improvements.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. The practice was supporting clinical staff to obtain their prescribing qualification.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date and had recently undertaken training on the management of Controlled Drugs which led to some changes in the way they worked.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.

Are services effective?

- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.

- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people especially since May 2018 when changes to the appointment system had been implemented. Staff we spoke with told us this had made the relationship between patients and themselves more positive.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were generally in line with the local and national averages for questions relating to kindness, respect and compassion.
- The practice gathered feedback from patients at every opportunity including via an electronic machine in the waiting room. This enabled patients to give feedback immediately following their appointments. The results showed consistent improvement and the results from July 2018 showed that 90% of patients were extremely or likely to recommend the practice to their family and friends should they need similar treatment and care.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way they could understand; for example, communication aids and easy read materials were available. We saw that nursing staff used pictorial information for patients to ensure they had a good understanding of any procedures they may be receiving.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice's GP patient survey results published July 2017 were generally below the local and national averages for questions relating to involvement in decisions about care and treatment. The survey results for July 2018 showed that 82% percentage of patients said the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment. This was slightly below the CCG average of 90% and the national average of 87%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the practice, and all the population groups, as requires improvement for providing responsive services.

We rated the practice and the population groups as requires improvement because;

Data from the GP patient survey 2017 and 2018 and NHS choices showed low patient satisfaction in relation to access to appointments. The practice record of complaints also supported this. Changes that had been made had been newly implemented and had not had time to be fully evaluated to ensure they could be sustained and effective to improve patient satisfaction.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- Results from the national GP patient survey published in July 2017 in particular relating to access to the practice were lower than local and national averages. We viewed results from the GP patient survey published in July 2018 which showed the practice were still lower than local and national averages for many outcomes.
- The practice understood the needs of its population and tailored services in response to those needs. The senior management team had held open public meetings to discuss the services the practice was able to offer and the challenges they faced.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice provided dispensary services for people who needed additional support with their medicines

including weekly blister packs and large format labels. They issued weekly prescriptions for patients who might be at risk if they had a large quantity of medicines at one time.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. The practice had been successful in recruiting clinical staff and prioritised continuity of care.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice worked with Suffolk County Council and Haverhill Council and had established a bus service to West Suffolk Hospital.
- The practice had kept the Kedington branch site open, although for limited hours, as it served a predominantly older population and this reduced the travel burden for some patients.
- Patients who lived near the Kedington branch surgery could collect their dispensed prescriptions from there.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients could be seen in the evening or on Saturdays for their reviews and for blood tests.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Are services responsive to people's needs?

- Appointments for GPs and nurses were available in the evenings and on Saturdays.
- Joint working was undertaken with the health visiting team and other agencies where families and children required extra support to keep them safe.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, evening and Saturday appointments.
- Nursing appointments were available in the evening and on Saturdays for cervical screening and healthy living advice.
- The practice used the electronic prescription service, so that people could collect their medicines directly from their community pharmacy without having to visit the practice.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Vulnerable patients were identified and offered appointments without triage, for example those with hearing difficulties.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients who failed to attend their appointments were proactively followed up by a phone call from a GP.
- The practice recognised that patients experiencing poor mental health had to travel a significant distance for specialist services. They were working towards providing these services locally.
- The practice worked with local voluntary services, for example Open Space and Suffolk Mind project.

Timely access to care and treatment

Patient feedback with regards to accessing care and treatment from the practice within an acceptable timescale for their needs was mixed.

- Following the poor patient satisfaction, the practice implemented changes to improve the access to ensure patients received initial assessment, test results, diagnosis and treatment in a timely way. Data from July 2018 still showed patients were unsatisfied with how they accessed care and treatment. These changes had been newly introduced and the impact of the changes had not been assessed yet to ensure they were effective and sustainable.
- Waiting times, delays and cancellations were managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Although the results from the GP patient survey were lower than the CCG and national averages patient reported the appointment system was easy to use since the new telephone and appointment system had been introduced in May 2018.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.
- The practice had received and responded to a significant number of complaints, a large number of these were related to the telephone system and access to appointments. Following the actions taken by the practice the number of complaints had reduced significantly.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. Staff we spoke with gave examples of when the management team had supported them to be open and honest and to share their experiences.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. Staff gave us examples of when they had received personal support to raise safeguarding concerns.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Reception staff had been supported and received training as care navigators and clinical staff were being supported to complete their prescribing qualifications.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders and the

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management board of the Suffolk GP Federation had oversight of safety alerts, incidents, and complaints. These were also shared at practice level to ensure learning.

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents. We saw evidence that these had been effective.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. Minutes of meetings were detailed and actions monitored, these were available to staff.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses, actions to take and monitoring processes.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.
- The practice had held open public meetings to discuss the challenges and plans for improvement with the population of Haverhill.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The Suffolk GP Federation were working with other local practices to sustain and improve the access to healthcare in and around Haverhill.

Please refer to the evidence tables for further information.