Dr T R S Bailey & Partners

Quality Report

Fred Archer Way,
Newmarket,
Suffolk,
CB8 8NU
Tel: **01638 666887**
Website: www.orchardhousesurgery.co.uk

Date of inspection visit: 11 December 2014
Date of publication: 23/04/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We visited Orchard House Surgery on the 11 December 2014 and carried out a comprehensive inspection. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services.

We found the practice was outstanding for providing well-led services and services for people whose circumstances make them vulnerable. It was also good for providing services for older people, people with long-term conditions, families children and young people, working age people (including those recently retired) 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.
- Patients said they were treated with dignity and respect and were involved in their care and decisions about their 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 that day. The practice offered flexibility to help meet patients' needs for example, by arranging a call

Summary of findings

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 structure 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 including:

- The practice employed a dedicated auditor whose role involved working closely with the Lead GP for IT. Their responsibilities included maintaining the practice's call and recall systems ensuring that patients who had long-term conditions or required review were invited and seen at the practice in a timely way.
- 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 improvements to the practice website, patient appointment times and provision of extended hours appointments. Action had been taken to improve these areas including systems to develop the PRG survey.
- There was a comprehensive and embedded system of clinical and non-clinical audits within the practice covering a broad range of clinical and non-clinical areas. For example the practice had implemented a number of pre-programmed batch clinical reports within SystmOne that ran at pre-set intervals and automatically sent the results to clinicians as a task to action before the audit cycle was repeated. There was evidence that this had led to improvements in outcomes for patients. We saw that the results of audits had been shared routinely across clinical teams.
- All patients who required an appointment with a GP were seen on the day their request was made. Requests could be made at any time of the day, and the practice had late night GP and nurse appointments to ensure patients not available during working hours could access appointments easily.
- The practice implemented a number of telephone consultations during the evening extended hours appointments for asthma reviews. This provided long term condition reviews for asthma patients that may have found it difficult to attend the practice during normal working hours or attend on-site evening appointments.
- 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 with clear communication and mutual support. There was a strong culture of shared learning, improvement and achievement to ensure that patients' needs were met.

However, there were also areas of practice where the provider should make improvements.

The provider should:

- Assess the risks relating to local post offices providing a collection centre for dispensed medicines.
- Assess the competence of reception staff to conduct prescription checks and ensure reception staff receive the appropriate training to undertake this task.
- Improve systems for the safe management of controlled drugs and improve security arrangements for the dispensary.

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. The practice was able to demonstrate that they provided safe services that had been sustained over time. There were processes in place to report and record safety incidents and learn from them. Staff were aware of the systems in place and were encouraged to identify areas for concern, however minor. Staff meetings and protected learning time were used to learn from incidents and clear records had been kept including any action taken. Risks to patients were assessed and well managed. Infection control procedures were completed to a satisfactory standard. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's 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 caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Reference Group (PRG). The practice had reviewed the needs of their local population and engaged with the Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Summary of findings

Patients reported good access to the practice and a named GP or GP of choice, with continuity of care and urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

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 were a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active Patient Reference Group (PRG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. It was responsive to their needs. Home visits and priority for appointments (for patients who were receiving palliative care) was available and prescriptions could be delivered to their home addresses by a local pharmacy. The practice adopted the Gold Standards Framework for the treatment of people nearing the end of their lives and requiring palliative care. Multi-disciplinary team meetings took place for elderly people with complex needs. External support was signposted and made available for them to access. Elderly patients had a named GP to receive continuity of care. Home visits and telephone consultations were available. The practice was pro-active in encouraging patients to receive flu and pneumococcal vaccinations.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice ran a Doctor First telephone consultation service which ensured patients had telephone access on the day to a GP and where required a face to face appointment. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. A GP telephone asthma review was available for patients one evening per week. The practice employed a dedicated auditor whose role involved working closely with the Lead GP for IT. Their responsibilities included maintaining the practice's call and recall systems ensuring that patients who had long-term conditions or required review were invited and seen at the practice in a timely way. Patients with long term conditions had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The Doctor First 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 appointments till 8.15pm on Monday evenings. The needs of the local working age population, those working in the local horse racing industry, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion, support, counselling and screening at the practice which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. Annual health checks for people with learning disabilities were undertaken and patients received annual follow-ups. Double appointment times were offered to patients who were vulnerable or with learning disabilities. All patients were able to register at the practice as temporary residents, regardless of their personal circumstances, including the homeless and members of the travelling community and be seen that day.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Carers of those living in vulnerable circumstances were identified and offered support including signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. A lead for

Summary of findings

safeguarding monitored those patients known to be at risk of abuse. All staff had been trained in safeguarding and were aware of the different types of abuse that could occur. Patients were supported by staff during their visit to the practice to ensure they received the appointment and treatment they required. We saw reception staff offered support, guidance and advice to patients throughout their visit to the practice and were quick to respond to patients or visitors who needed additional assistance and support.

People experiencing poor mental health (including people with dementia)

Good

The practice was aware of the number of patients they had registered who were suffering from 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 such as the community psychiatric nurse for provision of counselling and support. The practice provided support to a local low secure health unit that provided specialist assessment, care and treatment for patients with complex mental health disorders, intellectual disabilities and behaviours that challenge. Two of the GPs alternately visited this facility weekly to provide primary care services to these patients.

Summary of findings

What people who use the service say

We spoke with ten patients during our inspection. The practice had 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 22 comment cards, all the cards indicated that patients were more than satisfied with the support, care and treatment they had received from the practice. Comments cards also included positive comments about the services available at the practice, the improvements in appointment availability, the skills of the staff, the treatment provided by the GPs and nurses, the cleanliness of the practice, the support and care offered by staff and the way staff listened to their needs. Patients recorded they were very happy with the care provided and arranged by the practice staff. These findings were also reflected during our conversations with patients during and after our inspection.

The feedback from patients was extremely positive. Patients told us about the ability to speak or see a GP on the day. They described their experiences of care and praised the level of care and support they received at the practice. The patients we spoke with told us they were very happy with the service and they felt their treatment was professional and effective. We were told the GPs and nurses always gave them ample time during their consultation. They told us things were clearly explained to them and clinicians gave them sufficient time and information to be able to make decisions with regard to 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. We were given a number of examples of effective communication between the practice and other services. Patients told us how the practice had been able to expedite treatment and support for them across the services. Patients told us if they needed to complain they would speak to the reception team or the practice manager. We were told they felt their concerns would be listened to. Others were able to give us examples of when they had raised a concern, we were told the practice manager had been supportive and a resolution had been quickly sought. They told us they were happy with the way the practice had dealt with their concern and felt they had been listened to.

Patients told us they could always speak with a GP on the day and where necessary get an appointment when it was convenient for them and with the GP of their choice. Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing and reception teams and the practice manager were all very approachable and supportive.

Patients told us they were happy with the supply of repeat prescriptions. All the patients we spoke with commented this was the best practice they had been with and told us they would readily recommend the practice to other patients and were very happy with the practice facilities.

There was a supply of health care and practice information on display in folders in the waiting room area.

Areas for improvement

Action the service SHOULD take to improve

- Assess the risks relating to local post offices providing a collection centre for dispensed medicines.
- Assess the competence of reception staff to conduct prescription checks and ensure reception staff receive the appropriate training to undertake this task.

Summary of findings

- Improve systems for the safe management of controlled drugs and improve security arrangements for the dispensary.

Outstanding practice

- The practice employed a dedicated auditor whose role involved working closely with the Lead GP for IT. Their responsibilities included maintaining the practice's call and recall systems ensuring that patients who had long-term conditions or required review were invited and seen at the practice in a timely way.
- 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 improvements to the practice website, patient appointment times and provision of extended hours appointments. Action had been taken to improve these areas including systems to develop the PRG survey.
- There was a comprehensive and embedded system of clinical and non-clinical audits within the practice covering a broad range of clinical and non-clinical areas. For example the practice had implemented a number of pre-programmed batch clinical reports within SystmOne that ran at pre-set intervals and automatically sent the results to clinicians as a task to action before the audit cycle was repeated. There was evidence that this had led to improvements in outcomes for patients. We saw that the results of audits had been shared routinely across clinical teams.
- All patients who required an appointment with a GP were seen on the day their request was made. Requests could be made at any time of the day, and the practice had late night GP and nurse appointments to ensure patients not available during working hours could access appointments easily.
- The practice implemented a number of telephone consultations during the evening extended hours appointments for asthma reviews. This provided long term condition reviews for asthma patients that may have found it difficult to attend the practice during normal working hours or attend on-site evening appointments.
- 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 with clear communication and mutual support. There was a strong culture of shared learning, improvement and achievement to ensure that patients needs were met.

Dr T R S Bailey & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Dr T R S Bailey & Partners

Orchard House Surgery had implemented an appointment system that was based on a Dr First system. This system had been refined over the previous year to ensure patients received timely appointments. All patients are offered either a telephone or face-to-face appointment on the day they call the practice. The practice is open Monday to Friday from 8am to 6.30pm. Extended hours nurse and GP appointments are available on Monday evenings from 6.30pm to 8.15pm. The practice provides primary medical services to approximately 10327 patients and is situated in central Newmarket, Suffolk. The building provides good access with accessible toilets. Car parking facilities and bus stops are available nearby.

The practice has a team of eight GPs meeting patients' needs. Six GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there was one nurse manager, one nurse practitioner, three practice nurses, one associate practitioner and one health care assistant. There was a dispensary supervisor and two dispensers, the practice manager, the deputy practice manager, a reception manager, and a team of medical secretaries, reception and administration staff. Orchard House is a training practice and GP registrars provide clinics throughout the year. Medical students and student nurses also attended the practice for training. The practice provides a dispensary on site.

Patients using the practice had access to a range of other services and visiting healthcare professionals. These included, health visitors, midwives, dieticians, nurse led jockey medical clinics, cognitive behavioural therapists, Improving Access to Psychological Services (IAPT), mental health link workers and mental health consultants.

The practice provides services to a diverse population age group, in a semi-rural location.

Outside of practice opening hours a service is provided by another health care provider (Care UK), 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 this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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.

Detailed findings

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

How we carried out this inspection

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

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

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

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

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 11 December 2014. During our inspection we spoke with a range of staff including GP partners, practice nurses, health care assistants, the dispensers, reception and administrative staff and the practice manager. We spoke with patients who used the service. 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 22 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 monitored patient safety using a range of different methods including significant events analysis, complaints, national patient safety alerts and safeguarding adults and children. A Health and Safety checklist also monitored the risks to patients and staff.

Staff we spoke with were all aware of the systems in place at the practice to record incidents involving safety and were encouraged to bring such incidents to the attention of the practice manager or one of the GPs.

The practice was able to demonstrate that they had maintained a good track record on safety. We saw records to show that performance had been consistent over time and where concerns had arisen, for example with a complaint or a safeguarding concern, they had been addressed in a timely way. The manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. Learning from safeguarding reviews were communicated internally at the six monthly complaints and significant event and weekly practice meetings. In addition learning from safeguarding reviews were shared externally at the weekly multi-disciplinary team (MDT) Vulnerable and End of Life patients meetings.

We looked at the minutes of the staff meetings and found that learning had taken place. Significant events were a standing item on the agenda at staff meetings. Staff we spoke with displayed knowledge of the incidents that had taken place and the learning achieved as a result of them. For example we saw evidence of discussion around improving postal pathways within the practice following an issue raised by a GP. Staff were included in the discussion and all teams had looked at how systems could be improved, there was clear evidence of learning and improvements to systems undertaken. As well as discussing significant events and any learning outcomes with staff, we saw from minutes of meetings we looked at that these were discussed with other health providers outside the practice. This showed that ideas for improvement were shared.

Staff were aware of the procedures to follow when reporting a concern, whether it was a significant event or a more minor matter. They told us they were encouraged to report incidents so all could learn from them. We saw that staff had developed a culture of awareness for the various ways in which patients presented, in particular with fears and bereavement, to ensure they felt able to express their concerns and request help. We found that there was a positive culture amongst the managers and staff to report incidents to keep both staff and patients safe.

National Patient Safety Alerts were responded to in a timely fashion. GPs were informed of the relevant issues, patient records were updated and changes made to care and treatment where necessary. Alerts were also discussed at team meetings so clinical and non-clinical staff were aware of them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice worked with local safeguarding, domestic violence and young people's organisations to ensure the practice was aware of the needs of the patient population.

Practice training records made available to us showed staff had received relevant role specific training on safeguarding. We saw this was up to date, and where training updates were due these had been pre-booked. We asked members of medical, nursing and administrative staff about their most recent training. Staff were able to demonstrate how they would recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had dedicated GP's appointed as leads in safeguarding vulnerable adults and children. All clinical staff had received safeguarding training up to level three. The staff we spoke with were aware who these leads were and told us they knew who to speak to in the practice if they had a safeguarding concern.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system SystmOne, which collated all communications about the patient including scanned

copies of communications from hospitals. 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.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to alert staff of any relevant issues when patients attended appointments; for example vulnerable patients, patients diagnosed with dementia, transient patients or children subject to child protection plans.

A chaperone policy was in place. Chaperone training had been undertaken by all nursing staff, including health care assistants. Staff told us that nursing staff and health care assistants were used when chaperoning patients.

Records we saw showed that staff at the practice had been subject to criminal checks through the Disclosure and Barring Service.

Medicines Management

We assessed the arrangements for the management of medicines at the dispensary by observation, talking to staff and looking at records. We noted the arrangements in place for patients to order repeat prescriptions. Medicine supplies were handed to patients only after prescriptions were authorised by the doctors. Patients we spoke with told us they received their repeat prescriptions promptly, did not experience delays in the supply of their medicines and received their repeat prescriptions within 48 hours.

A patient group survey in October 2013 showed a high level of patient satisfaction with the dispensing services. The dispensary provided a weekly medicine delivery service to local post offices for patients who lived in rural areas, where their medicines were handed to them by post office staff. However, we noted that the practice had not assessed the risks relating to this. We discussed these concerns with the GPs and the practice manager and they confirmed that they would be putting a risk assessment in place following our inspection.

Dispensary staffing was in line with published guidance and dispensers had attained suitable qualifications and received on-going training and development. Members of dispensary staff were assessed as competent annually. However, at times when there was only one member of dispensing staff on duty, prescription checks were conducted by receptionists who had not received training or been assessed as competent to undertake the task. Therefore we could not be assured patients were always supplied their medicines after safe procedures had been followed by staff who were suitably trained and competent. We discussed these concerns with the GPs and the practice manager. They confirmed that, following our inspection, arrangements would be made to risk assess the competence of reception staff to conduct prescription checks and to ensure reception staff received the appropriate training.

A senior dispenser told us there were monthly departmental meetings to discuss issues arising. We noted there had been few actual dispensing errors recorded. However, there were a significant number of 'near miss' dispensing errors that had been identified before patients received their medication. This demonstrated that the practice had taken action to address issues before they could adversely impact patients. We were also told about controlled drug discrepancies where register records had been missed and not promptly identified. Controlled drugs are medicines that the law requires are secured in a special cupboard and their use recorded in a register. There was scope to improve the recording of, investigation around and learning from controlled drugs errors. We discussed these concerns with the GPs and the practice manager. The practice confirmed that, following on from our inspection, they had plans to review and improve controlled drugs management. We were told the practice would put audits in place to monitor this.

We looked at the arrangements in place for the security of medicines at the practice. We found that at times medicines could be accessed by members of staff other than those authorised to access them. There was also scope to improve security arrangements for the keys to the dispensary so that they could be accessed only by authorised persons. We found that whilst prescription forms were kept securely, record-keeping practices did not allow them to be fully accounted for. We discussed these concerns with the GPs and the practice manager. The practice told us that, following our inspection, they had plans to improve security for dispensary keys and accountability for prescription forms and pads. We saw that there were effective systems in place to monitor patients on potentially dangerous medicines. For example immunosuppressant's (Immunosuppressant's are powerful medicines that dampen down the activity of the body's immune system)

Good

Are services safe?

Policy documents relating to medicine management and dispensing practices were regularly updated on an annual basis which members of dispensary staff recorded that they had read and acknowledged.

Cleanliness & Infection Control

The practice had identified a lead for infection control and this was the practice nurse. They had undertaken training to enable them to provide advice on the practice infection control policy to other staff members. The infection control policy was stored on computer and a procedure manual was also available for staff to refer to. All staff received induction training about infection control specific to their role. There was also a policy for needle stick injury. Staff understood the importance of ensuring that the policies were followed.

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.

Staff we spoke with knew how to handle patients' specimens appropriately, and we saw a member of the reception staff receiving a patient's specimen correctly. Bags and gloves for staff used when handling specimens were available behind the reception.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. The practice manager told us they did a daily visual audit of the practice. In addition the practice had undertaken regular audits of the cleaning undertaken at the practice. Areas highlighted for attention and the actions taken were recorded. The practice employed cleaning staff to oversee daily cleaning at the practice and held regular meetings with the cleaners to review the results of the cleaning audits and update the cleaning schedules.

We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum at the practices. We saw that there were body fluid spillage kits which enabled staff to clean any contamination or spillages effectively.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

We found that there was sufficient equipment in use at the practice to meet the needs of patients. This included disposable medical equipment for use on one occasion only. Equipment in use at the practice included blood pressure monitors, weighing scales, nebulisers and spirometers.

All equipment was regularly calibrated to ensure it was working correctly. Electrical equipment was tested to ensure it was safe. Records were kept that reflected that these checks were being undertaken on a regular basis.

There were sufficient quantities of personal protective equipment to keep staff safe. These included aprons and disposable gloves. A system was in place for stock control.

Staff we spoke with told us that they were satisfied with the quality and quantity of equipment made available to them to enable them to carry out their roles in providing examinations, assessments and treatment.

Staffing & Recruitment

The practice had a recruitment policy that had been reviewed and was fit for purpose. It explained the process from identifying a vacancy through to employment. It detailed the requirement to check people's identities, qualifications and experience and whether they were registered with the relevant professional body. 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 via the Disclosure and Barring Service. We checked the records of six recently recruited staff. The records showed that staff were interviewed, and criminal records checks were carried out. Staff were provided with contracts of employment.

Good

Are services safe?

Each new member of staff, including GPs were required to go through an induction process. This involved being made aware of how the practice runs, familiarisation with the patient record system, health and safety information and the expectations and standards that the practice wished to maintain.

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 they were enough staff 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.

Non-clinical staff had been trained in a way that they were able to cover each other's roles through absence due to annual leave, training or sickness. There was a suitable mix of skills and experience of staff to meet the needs of patients. Where staff shortages occurred, because staff were multi-skilled they could interchange roles easily to ensure the practice ran smoothly. We saw that staff numbers were regularly monitored to ensure that enough staff were on duty. Staff told us there were usually enough staff to maintain the efficient running of the practice and there were always enough staff on duty to keep patients safe.

The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice had a health and safety policy and a designated lead for oversight of safety and risk. A practice risk assessment was in place that identified risks to staff and patients and how to minimise or reduce them.

The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis. Staffing establishments including staffing levels and skill mix were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and levels of staff well-being.

We saw there were a range of audits of health and safety issues undertaken. These included infection control, prescribing, cleaning and responding to busy periods. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Equipment was monitored regularly to ensure it was working correctly and safe to use. Any findings that had been identified were shared with staff at their meetings.

Staff meetings and protected learning time were used to discuss risk with clinical and non-clinical staff and any learning identified was cascaded to them. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Where referrals to specialists were urgent these were actioned the same day so that patients could receive the earliest appointment possible.

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

Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations. Staff confirmed if they had daily concerns they would speak with the GP's, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinician's in the practice.

We saw that staff at the practice had received cardiopulmonary resuscitation (CPR) training. The staff we spoke with confirmed this and training certificates were available.

There was information displayed in the reception area, in the patient leaflet and practice website regarding urgent medical treatment both during and outside of surgery hours

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency first aid equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) oxygen and nebuliser. Those members of staff we spoke with were aware of the location of this equipment. Records confirmed that it was checked regularly to ensure it was fit for use.

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 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 undergoing review. We saw that there were plans 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 access to the building, power failure, loss of telephone access and adverse weather conditions. The document also contained relevant contact details for staff to refer to.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training. Staff told us regular fire drills were undertaken

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice reviewed, discussed and acted upon best practice guidelines and information to improve the patient experience. A system was in place for National Institute for Health and Care Excellence (NICE) quality standards to be distributed and reviewed by clinical staff. The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF). QOF is a national data management tool generated from patients' records that provides performance information about primary medical services. We saw that the practice had used this information to improve services for groups of patients, including patients with asthma, diabetes and chronic kidney disease.

We saw that clinical templates were in place to deliver consistent needs assessments and recording for all patients. The practice manager told us the lead GP for IT developed templates and protocols for the practice to ensure that consistent and relevant information was captured during consultations. We were told there was a read code protocol to ensure correct read coding was consistently used in patients' records. The practice manager told us and we saw evidence that importance was given to clinical IT developmental work and the partners' ensured one clinical session per week was dedicated to this. Staff told us that in addition to this there were often ad hoc meetings during the day to ensure that good practice was discussed and shared between clinicians. We were told that read codes were audited and the outcomes shared and discussed with staff.

We found detailed care plans in place for people with end of life needs and monthly palliative care meetings were held between practice staff and partner services. A palliative care template was used to record the care needs of patients approaching the end of their life. This was a multi-disciplinary record, including input from the hospice team, district nurses, the voluntary sector and the out of hour's service. As a result patients' holistic, cultural and medication needs were recorded so that healthcare professionals could ensure that the patient received the best and most appropriate care at all times.

We found that patients had their needs assessed and that their care was planned and delivered in line with guidance and best practice. Patients were referred in line with guidance to secondary and other community care services. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. A coding system was used to ensure that patients with a chronic disease were placed on a register in order that their needs and medicines could be reviewed effectively. Clinicians were alerted by the system when patients were due to have a review of their condition or medication. They were also prompted to follow up review requests if patients did not attend for their review appointment.

There were processes in place to review patients recently discharged from hospital. We saw that GPs undertook reviews where appropriate and used the "Two Week" wait referral system when required, (two week wait referrals are a fast track referral system for managing urgent referrals for patients with suspected cancers).

We saw that care and treatment decisions were based on people's needs without unlawful discrimination. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

GPs held responsibility for local care homes and attended the homes to proactively manage and co-ordinate patients care.

The GPs and nurses we spoke with were familiar with current best practice guidance, and carried out their assessments and consultations in line with guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found that clinical staff had a system in place to receive relevant updates about new guidelines that were then put into practice with their patients. The GPs told us they led in specialist clinical areas such as reproductive and sexual health and atrial fibrillation. The nurses supported this work, but led on a range of health promotion clinics, smoking cessation advice, screening services such as chlamydia, minor illness, baby, childhood and travel vaccination and minor injuries treatment.

GPs attended training sessions and undertook e-learning modules that provided them with clinical updates so that their learning was continuous. Clinical staff we spoke with and the evidence we reviewed confirmed that these actions

Good

Are services effective?

(for example, treatment is effective)

were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

Patients we spoke with on the day told us that they were extremely happy with their assessments and said that their needs were met by the clinicians.

Patients received appropriate advice about the management of their condition including how they could improve the quality of their lives. We saw extensive evidence of comprehensive care planning for patients with long term conditions, patients in care homes and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission and end of life care. The practice ensured care plans were accessible to other agencies, such as out of hours services to ensure their full involvement and to facilitate sharing of information. The practice referred patients appropriately to secondary and other community care services.

The GP partners told us that referrals were regularly reviewed in conjunction with the clinical commissioning group. Patients were referred to specialists and other services in a timely manner. Where urgent, these were made on the same day, but in general within 48 hours.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice employed a dedicated auditor whose role involved working closely with the Lead GP for IT. The practice manager told us one of the main responsibilities of the auditor was to maintain the practice's call and recall systems ensuring that patients who had long-term conditions or required review were invited and seen at the practice in a timely way. We were told those patients who did not respond to invitations to attend for review were exception reported at the appropriate stage and in line with guidance given.

The practice had a system in place for completing a wide range of clinical audit cycles. These were divided into several areas including; in-house pre-programmed electronic audit cycles, these were clinical audits set up to run within SytmOne. These ran automatically at pre-set intervals and sent results to the clinicians to take the appropriate actions before the next audit cycle was repeated. These included audits of patients with a diagnosis of dementia who required a blood test, audit of patients with a diagnosis of cancer who required a cancer care review and patients on anti-depressant medication who did not have a diagnosis.

In-house manually triggered electronic audit cycles. These were audits that could not be electronically pre-programed due to their complexity, the requirements of the audit or any changes in the audit standards. These included monthly audits of emergency admissions to ensure vulnerable adults and patients in care homes were provided appropriate community care to reduce further emergency admissions. Quarterly audits to enable identification and management of vulnerable adults as appropriate. All new patients were then discussed at multidisciplinary meetings to ensure support systems were in place. Six monthly audits to identify patients with dementia who had an active repeat prescription for anti-psychotic drugs for review. The aim of this audit was to reduce prescribing of anti-psychotic medication in patients with dementia where appropriate. The practice also undertook quality and outcomes framework audits. The practice had built on a number of basic audits to ensure the practice were able to monitor their achievements in providing quality care to their patients.

There were systems in place to regularly monitor other services within the practice including hospital referrals. The practice manager told us the results of these audits were shared and discussed with the local hospitals. Appointments within the practice were audited approximately every six months or when there was an unexpected increase in appointment demand and the outcomes used to make adjustments to the appointment schedule. Prescribing audits were undertaken regularly, the practice worked alongside the local CCG medicines management team to monitor its prescribing. There were also standalone audits where members of the practice team undertook an audit on a subject of interest to them, such as record keeping and contraceptive implant removals. We were told these audits had a minimum of two cycles and were then repeated as required at a future date.

We looked at several clinical audits on the day of our inspection. An analysis of the findings had taken place and where areas for improvements were identified these had

been documented and actioned. There was evidence that this had led to improvements in outcomes for patients. We saw that the results of audits had been shared routinely across clinical teams. Some clinical audits were linked to national patient safety and medicines alerts where the number of patients affected by them was reviewed and changes in medicines made, to improve the outcomes for them.

Non-clinical audits also took place. We saw examples of regularly repeated infection control audits, vaccination storage audits, cleaning audits and smear quality audits. The practice had action plans in place to address the results and outcomes of these audits. We saw the outcomes, action plans and any learning identified from these audits were discussed and shared with staff.

The practice used the Quality Outcomes Framework (QOF) to monitor their performance against national targets and screening programmes to monitor outcomes for patients. We found that the practice was achieving above the local CCG average and was in line with national averages. For clinical areas such as Dementia, Hypothyroidism, Epilepsy, Cancer, Heart Failure, Rheumatoid Arthritis and Osteoporosis the practice had achieved 100% for care reviews and monitoring. The practice had also achieved high targets across areas including childhood immunisations, with the practice achieving over 90% for all children at the practice eligible for childhood vaccination, with the exception of the Meningitis C where the practice achieved 64.6% of those eligible vaccinated. The practice performance was the subject of monthly monitoring to ensure that patients were receiving the best outcomes.

There was a protocol for repeat prescribing which was in line with national guidance. Patients receiving repeat prescriptions had been reviewed by the GP. Medicines were reviewed annually or more frequently when necessary. Repeat prescriptions were not issued until the patient had attended the practice for their medication review. All new prescriptions were checked and authorised by one of the GPs prior to being given to a patient.

The practice had implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were discussed and care and treatment planned to meet patient's circumstances and wishes.

Staff meetings were used to discuss and monitor performance to ensure standards were maintained. Minutes of the meetings reflected that performance of the practice was regularly discussed and all staff were involved in the discussion.

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 ischaemic heart disease, asthma and hypertension and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs and GP dispensary lead 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.

Effective staffing

Practice staffing included clinical, managerial, dispensary and administrative staff. We viewed training records and found that all staff had received annual basic life support and safeguarding of children and vulnerable adults. Staff had also been trained in the use of the equipment used at the practice. Training of all staff was regularly reviewed.

We found that staff files contained details of the training they had undertaken and certificates were available for us to view. Records reflected that the practice nurses had received additional training in the specialist areas of diabetes, cervical cytology, immunisation and the treatment of anaphylaxis. The practice nurses were supported to undertake their continuous professional development to maintain their skill levels. The nurse manager and practice nurses belonged to the Suffolk nurses network and regularly attended meetings and training sessions.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation, (every GP is

Good

Are services effective?

(for example, treatment is effective)

appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff had received appraisals annually and records held dated back over several years. Staff we spoke with told us these gave them the opportunity to discuss their performance and to identify future training needs. Staff were part of a two way process that gave them the opportunity of discussing how they felt working at the practice and what training they needed to do their job effectively. All staff members we spoke with felt supported in the workplace. Personnel files we examined confirmed the appraisals included reviews of performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as vulnerable adult and child safeguarding. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. The practice was also involved with medical student teaching. The practice manager told us there were often medical students on placement at the practice and the practice was involved with the Graduate Course in Medicine in association with Cambridge University Clinical School. This meant that the practice had students working with them throughout the four years of their training course. We were told the practice also supported student nurses on GP placements throughout their training.

Where GP locums were used their qualifications and experience were checked prior to being allowed to work at the practice. This included references and the most recent Disclosure and Barring Service check. Locum GPs were provided with a locum handbook and received an induction process to ensure they understood how the practice operated.

Reception and administrative staff had undergone training relevant to their role. For example, one member of staff who had joined the practice within the last 12 months described their induction programme which included supervision, group training and e-learning programmes. Staff described feeling well supported to develop further within their roles.

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 a local care home which provided support to elderly patients. Records we examined showed that these patients had received physical health checks in line with best practice guidance. A representative of one nursing home described the excellent and responsive support provided to the staff and patients by the practice manager and the GPs.

We also saw how the practice worked collaboratively with other services, hospitals and consultants to the benefit of its patients.

Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing 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. The practice could demonstrate that all results and discharge summaries had been followed up appropriately within the last year.

There were regular meetings, involving other different professionals, to discuss specific patients' needs. For example patients with end of life care needs, and children at risk. These meetings were attended by district nurses, social workers and palliative care nurses. 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.

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.

Good

Are services effective?

(for example, treatment is effective)

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record SystmOne was used by all staff 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. The practice used information received to ensure patient care was being planned effectively. For example, Hospital discharge letters that had been received were brought to the attention of one of the GPs, action taken if necessary and the patient's record updated

Electronic systems were also in place for making some referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they can attend to book their outpatient appointments.)

The practice also has signed up to the electronic Summary Care Record and had plans to have this fully operational by 2015. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information).

The practice provided support to a local low secure health unit that provided specialist assessment, care and treatment for patients with complex mental health disorders, intellectual disabilities and behaviours that challenge. Two of the GPs alternately visited this facility weekly to provide primary care services to these patients.

We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. The local GP out-of-hours provider shared patient information in a secure and timely manner and patient records were updated daily.

Consent to care and treatment.

There was a practice policy for documenting consent for specific interventions. For example, cervical smears, childhood immunisations and minor surgical procedures. Patient's verbal consent was documented in their electronic patient notes. We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions.

Due to the location, the local racing industry and a large transient population working within the racing industry, the practice saw a wide range of multi-cultural patients. There was good access to translation services such as a telephone translation service. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patients' preferences for treatment and decisions.

All staff were aware of patients who needed support from nominated carers and clinicians ensured that carers' views were listened to as appropriate. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. We saw examples of support provided to vulnerable patients from all levels of staff within the practice. All clinical and reception staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Reception staff were able to give clear examples of how they would ensure young patients had access to clinicians.

The practice confirmed that they had not used restraint in the last 3 years. Staff were aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

New patients who registered at the practice were offered a consultation for a new patient registration health check with a nurse to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height, weight, BMI). Patients over 16 years of age were asked to complete a patient health questionnaire which included a request for information on the patient's smoking and alcohol intake and advice on how to access smoking cessation clinics and alcohol support. The GP was informed

Good

Are services effective?

(for example, treatment is effective)

of all health concerns detected and these were followed up in a timely manner. Patients with long term health conditions or who were prescribed repeat medications were seen by a GP to review their repeat medications.

We saw the New Patient's Registration pack which included a patient health questionnaire, consent for patient care data information sharing and information on participating in the practice patient participation group (this is a group of patients registered with the practice who have an interest in the service provided by the practice). Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was the subject of regular monitoring and data reflected that targets were being achieved. There was a blood pressure monitor available for patients in the reception. This was located behind a screen and was available for patients to self-monitor their blood pressure. The machine printed out a recording of the results for patients to hand to their GP, nurse or the reception team. This information was then added to the patient's medical record and was brought to the attention of their GP. This enabled the clinicians to monitor patients' health and identify any potential blood pressure problems.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice was pro-active in identifying patients, through posters in the surgery, the information screens in reception, letters to patients and telephone calls. There was a clear policy for following up non-attenders. The practice manager told us a drop in flu vaccinations uptake had recently been identified through audit and this was due to an error in the computer system. We were told the practice had an action plan in place to avoid recurrence of this issue.

The practice identified patients requiring additional support. They kept a register of all patients who were carers or with a learning disability and were aware of the numbers that had registered with them. We saw that these patients attended for their annual review of their condition. Care plans were regularly reviewed. Signposting for additional support was provided for patients, their relatives and carers to organisations such as Age UK Suffolk and Suffolk Carers. A Carer Advisor attended the practice for regular clinics. A carer's notice board in the practice reception area gave patients details of when these sessions were held.

The computerised record system was used to 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.

Travel vaccinations and yellow fever vaccinations were available at the practice. Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about services to support them in doing this, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being. This encouraged patients to be more proactive about their health and aware of when to seek help.

There was a large range of health promotion information available at the practice. This included information on safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers on the noticeboards and information monitors in the reception area.

There was also a range of other services provided from the practice premises by visiting healthcare professionals. These included, dieticians, nurse led jockey medical clinics, cognitive behavioural therapists, Improving Access to Psychological Services (IAPT), mental health link workers and mental health consultants.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed that all staff spoke with patients in a friendly, professional and helpful manner. All staff spoken with demonstrated a good understanding of how patient's privacy and confidentiality was preserved. Reception staff explained how patients could request a private room to discuss anything they did not wish to discuss in the waiting area and this would be arranged. A notice board in reception provided photographs and names of each member of staff at the practice and their role within the service.

Patients who used the service told us they felt supported and well-cared for. During our inspection we overheard and observed that staff responded compassionately to patients in discomfort or emotional distress. We noted that staff approached patients in a person centred way; we saw they respected patients individual preferences, habits, culture, faith and background.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey with a 41% completion rate and a survey of patients undertaken by the practice's Patient Participation Group. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with dignity and respect. For example, data from the national patient survey showed 100% of respondents had confidence and trust in the last nurse they saw, 96% of the respondents felt their overall experience of the surgery was good, 94% responded that the nurses were good at treating them with care and concern, 96% felt the nurses were good at giving them enough time and explaining their treatments. 98% of the respondents reported they had confidence and trust in the last GP they saw, 96% responded that the last GP they saw was good at giving them enough time and explaining things to them, 93% reported that the GPs were good at involving them in decisions and 96% of respondents reported the GP was good at listening to them. 96% reported the receptionists to be helpful and 86% reported they found it easy to get through to the surgery by phone.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 22 completed cards and all were very positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were professional, experienced, caring and supportive. They said staff treated them with dignity and respect. We spoke with ten patients on the day of our inspection and also telephoned a number of patients following the inspection. All told us they were very satisfied with the care provided, the ease of speaking with and seeing a clinician when they needed to and said they were treated with compassion and respect by all staff and their dignity and privacy was always 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 and treatment room doors were closed during consultations, consultation and treatment rooms were away from the reception and waiting room areas and conversations taking place in these rooms could not be overheard by patients waiting or in the corridors. Patients we spoke with were aware of the availability of chaperones if they required them. They told us they were very satisfied with the way their consultations had been conducted.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk and staff wore mobile headphone receivers and microphones which helped keep patient information private. This prevented patients overhearing potentially private telephone conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

We saw staff were supportive and caring towards vulnerable and homeless patients when they attended the practice. In addition they took the time to follow up and ensure these patients were accommodated in their need to be seen by a clinician.

Staff told us 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 practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient survey information and completed comment cards we reviewed showed patients responded very positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. Patients we spoke with told us they were satisfied with the explanations of their care and treatment by the GPs and nurses. We were told they felt the GPs and the nurses explained things in a way they understood and took the time to provide the explanations.

The more vulnerable patients such as the elderly with complex needs, patients with long term conditions and those suffering from dementia were monitored regularly through the use of care plans. Where appropriate, we saw that the views of relatives were sought and explanations provided to help them understand the best type of care and treatment that met people's needs.

The patient survey information we reviewed also reflected that patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The practice was rated well in these areas. Patient feedback on the comment cards we received was also very positive and aligned with these views

Patient/carer support to cope emotionally with care and treatment

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

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

We saw evidence, during our inspection, of how well patients and families were supported by the practice. Staff we spoke with said that patients at the end of their life and their family were provided with whatever support they needed.

Good

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 systems in place to maintain the level of service provided. The practice understood the needs of the local population and took appropriate steps to tailor the service to meet their needs. This included flexibility, choice and continuity of care. The practice provided support to a higher than average transient population. Homeless patients and those patients registered at other practices who could not access an appointment at their registered practice were provided access to an appointment on the day at the Orchard House practice.

Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. 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 from a GP. 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 patient survey results reflected these comments.

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 appointment and they were very complimentary about the speed at being able to speak to or see a GP or nurse.

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 achieved and implemented the gold standards framework for end of life care. They 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 recognised the needs of the local industry and provided evening appointments with both GPs and nurses to provide access to care and treatment.

The practice worked closely with and signposted patients to local support services such as Suffolk Wellbeing and the drug and alcohol recovery team to provide counselling, healthcare and education. The practice also worked closely with Racing Welfare, a charitable support group providing help for stud, stable and support staff within the horse racing community and industry. Patients were provided with additional information and support and encouraged to be more proactive in managing their conditions.

Tackle inequity and promote 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 ground floor.

There were accessible toilets and baby changing facilities available. The practice had access to a telephone translation service.

Staff had access to an interpretation and translation service. 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.

Equality and diversity training had been provided to staff.

Access to the service

The practice ran a 'Doctor First' 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. We were told and

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. 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 nurse and GP appointments on Monday evenings from 6.30pm to 8.15pm. The practice manager told us that as not all the extended hours doctor appointments were fully utilised, the practice had implemented a number of telephone consultations during the evening for asthma reviews. We were told this was popular with patients as it provided long term condition reviews for asthma patients that may have found it difficult to attend the practice during normal working hours or attend on-site evening appointments.

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 practice and links to other organisations and interactive tools such as fitness and quit smoking widgets (a widget is a self-contained code that displays a program, or a piece of a program, to a computer or a mobile smartphone) and interactive health tools such as alcohol unit calculators and healthy eating self-assessments. The practice leaflet was available in Polish as well as English. The website was also available in 91 languages.

The practice gave priority to patients with emergencies and to children. Some appointment times were blocked off for this purpose. 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.

The practice ran clinics for people with long term conditions. However the practice had recognised the timing of these did not always provide ease of access for elderly patients and had therefore made adjustments to the provision and timing of these. There were health promotion clinics and screening available, such as for cervical smear, chlamydia and smoking cessation.

Signs were available in the reception and waiting room area that explained the appointment system. It also explained how to obtain emergency out of hour's advice through the 111 system.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

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 received in the previous twelve months had been dealt with in a timely manner. Learning outcomes had been cascaded to staff within the practice.

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 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 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. They told us they felt valued by the Partners and the management team and felt their views and opinions about the provision of service at the practice were listened to and acted on.

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 a very clear leadership structure within the management team. This included the partners, the practice manager and team leaders such as the lead nurse, reception co-ordinator and the lead dispenser. Designated leads included infection control, chronic disease management such as asthma, pharmacy/dispensing, safeguarding, 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 practice manager and GP Partners took an active role in overseeing all systems in place at the practice to ensure they were consistent, safe and effective. Policies and procedures were kept up to date and we saw that staff received training appropriate to their role

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 it was performing above local and in line with national standards. 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 prescribing medicines, cleaning, appointment availability, health and safety risk assessments 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 regular basis to ensure that patients and staff were safe. The IT lead was able to demonstrate on SystmOne that all results, reports, discharge summaries and out-patient letters were dealt with within one working day and any urgent ones were brought to the immediate attention of the duty GP.

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 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.

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 practice supported the local CCG Locality Meetings by providing free premises where these may be held.

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, vaccinations and team lead. The senior partner was the Caldicott Guardian and team lead for building maintenance and planning. 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

Are services well-led?

Outstanding ☆

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

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.

Practice seeks and acts on feedback from users, public and staff

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 noted that from the last GP patient survey in 2014 that patient satisfaction was high. The practice manager told us this had in itself led to an increase in patient numbers, 96% of respondents to the patient satisfaction survey describe their overall experience of the practice as good and 91% responded they would recommend the practice to someone new to the area. 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.

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 this had increased in size to 336 members. Areas highlighted and actioned from the PRG 2013 patient survey included; improvements to the practice website, patient appointment times and provision of extended hours appointments. Action had been taken to improve these areas including systems to develop the PRG survey.

The practice gathered feedback from staff through team meetings and the appraisal process. Staff we spoke with told us that they were encouraged to provide feedback and to contribute ideas for improvement. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available to all staff in the staff handbook.

Management lead through learning & improvement

We viewed records that demonstrated effective appraisal processes had been in place for a number of years. 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.

The practice supported an honorary GP. This is a qualified and experienced GP who was also a qualified pharmacist and a pharmaceutical physician who worked under the supervision of one of the GP partners in order to ensure their clinical accreditation remained up to date. The practice manager told us the practice had a history of supporting general practitioners who work in other specialist areas and wanted to maintain their general practice expertise.

One GP partner at the practice was actively involved as a CCG Board Member/Associate during the first 2 years of its development and led on Public Health matters for the local Clinical Commissioning Group (CCG).

In 2013, four of the GP Partners were awarded a Fellowship of the Royal College of GPs, making a total of five partners in total at the practice who had achieved this award. One of the partners was also an award winner of the 21st Annual Pilkington Prize 2014, which relates to the quality of teaching within Cambridge University.

In 2014 the Practice Manager was awarded the Practice Manager of the Year Award for the East of England from the Royal College of GPs. The Practice Manager was also an active member of the Suffolk Practice Managers' Group and attended regular meetings to network with other Practice Managers and the Local Medical Committee.

Other training achievements by members of staff supported by the practice included; a healthcare assistants who was one of the first nationwide to successfully

Are services well-led?

Outstanding ☆

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

undertake the associate practitioner training. This member of staff now worked at a more advanced level and was involved in much of the patient review and care planning work at the practice. Another healthcare assistant was working towards achieving a level three National Vocational Qualification (NVQ). The reception manager achieved a Business and Technology Educational Council (BTEC) Level 2 in Workforce Development in 2013. The deputy practice manager achieved an NVQ in Management Level 3 in 2014. One Dispensary Assistant achieved an NVQ Level 2 in General Practice Dispensing in 2014. The senior practice nurse completed their Nurse Prescriber training in 2014 and the healthcare assistant and associate practitioner won the Live Well Suffolk Stop Smoking Award 2014, first place for the most patients who had stopped smoking in a small practice. The practice manager told us this was the second award of this type they had won.

The practice was a GP training practice providing training for GP registrars, medical students and on occasion student nurses. 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.