Dr Flather & Partners

Quality Report

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Date of inspection visit: 31 March 2015
Date of publication: 04/06/2015

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?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Flather and Partners (also known as Hadleigh Boxford Practice Group) on 31 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the six population groups it serves.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles. Most staff had received an appraisal to identify and plan further training needs.
- Patients told us they valued the services provided to them. Staff treated them with compassion, dignity and respect and they were involved in their care and treatment decisions.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment and that there was continuity of care. Urgent appointments were available on the same day.
- The practice had good facilities and had established relationships with other health and care professionals. They were well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice had signed up to a local initiative for being a dementia friendly town. They had completed some refurbishment of the premises to make it easier for patients with dementia to orientate themselves within the building.

Summary of findings

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

Importantly the provider should:

- Record the relevant meetings to demonstrate that medicines incidents are monitored, trends are identified and action is taken to reduce any risk of reoccurrence.
- Provide additional training for the infection control lead and provide protected time for the role.
- Review the arrangements for sharing and discussing changes in best practice guidelines with all relevant staff and the implications for the practice.
- Review clinical meetings so that all clinical staff have regular opportunities to review clinical care and practice.
- Ensure that all non-clinical staff receive annual appraisals.
- Complete an audit to ensure that people's consent to treatment is recorded.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to staff although learning was not always widely shared with all relevant staff to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe although recent changes to the nursing team meant that there may not be sufficient numbers of nurses to meet patient's needs at all times. This was being reviewed.

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. However there was no process in place to review changes in the guidance as a team and discuss the effect on the care provided to patients. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Most staff had received training appropriate to their roles. Further training needs had been identified and training was planned to meet these needs. There was evidence of appraisals and personal development plans for clinical staff but some non-clinical staff had not had an appraisal for several years. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients told us they were treated with care, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available to them was easy to access and presented clearly to them. We also saw that staff treated patients with kindness, consideration and respect. They took action to maintain confidentiality of patients personal information.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to

Summary of findings

secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy that was shared with staff. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular meetings to review the quality of the service being provided. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active.

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

In response to local need the practice developed a role for the Nurse Practitioner (NP) to visit the three residential homes and one nursing home they supported. The NP visits regularly each week spending up to three hours at each home. This arrangement provided continuity of care for patients and time to provide education and training for care home staff. It also allowed opportunities for working with other community based professionals. One GP was the lead for the care homes and worked with the NP to ensure that patients' needs were met.

The practice were taking part in a local initiative led by the church along with the care homes. This aims to support patients and their families through the grieving and bereavement process.

The practice held monthly multidisciplinary meetings to discuss terminally ill patients and older people with complex care needs. Staff worked with patients and families to develop Advance Care Plans so that patients were cared for in the way they wished and supported to remain in their preferred place of care at the end of life. This included working closely with the Hospice at Home team and the community nurses. The practice routinely informed the out of hours service about their patients who had particular individual needs to ensure they received care in line with their wishes.

The practice had a community care practitioner, an occupational therapist and a volunteer from Age UK in the surgery on a weekly basis to give advice and support for patient's social care needs. They also attended the monthly multidisciplinary team meetings.

People with long term conditions

Good

The practice offered nurse led clinics dedicated to long term conditions. These included diabetes, asthma and chronic obstructive pulmonary disease. The clinics were further supported by advice from specialist nurses in diabetes and respiratory diseases.

The practice worked closely with secondary care at the local hospital. It was one of the first local practices to host the new Integrated Diabetes Service. It was also part of a new respiratory pilot project involving a respiratory specialist nurse and Consultant.

Summary of findings

Practice nurses provided visits to housebound patients to provide regular checks of their long term conditions. Other community based services were based within the practice such as physiotherapy, falls assessment and occupational therapy rehabilitation.

Families, children and young people

Good

Midwives, health visitors and school nurses are based at the surgery. This enabled the practice team to have close contact and build positive working relationships. For example routine blood tests taken by the midwives are reviewed by the patients GP so that action can be taken if necessary before the patient attends the next antenatal clinic appointment.

Childhood immunisation clinics were run on a regular basis and the practice achieved high uptake from patients. A contraceptive service was offered and included fitting/removing implants or IUDs.A condom scheme was provided through the dispensary.

A community paediatrician provided consultations in the practice on a monthly basis.

Working age people (including those recently retired and students)

Good

Patients of working age could use the 24 hour phone booking system (Patient Partner), online booking or arrange their appointments via more traditional methods (by phone or in person). Extended opening hours were available between 7.00 and 8.00am. All clinical staff offered a telephone consultation option and tried to be flexible to meet patients appointment request to suit their working lives.

The practice held a range of outreach clinics and services that patients found convenient. For example speciality outreach teams for Ear Nose and Throat, Dermatology and chemotherapy clinics run weekly.

Practice staff told us they constantly review ways to improve upon the services provided and offer greater convenience to their patients. For example they planned to start a well-being service in partnership with the Leisure Centre and Suffolk County Council.

Patients received appointment reminders by text and post. Annual flu jab clinics were held on a Saturday morning and have been very successful in vaccinating high numbers of at risk patients.

Weekly dedicated minor operations sessions were available. The practice also provided smoking cessation advice, travel and health checks for patients over the age of 40.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice provided support to one residential home for young adults with behavioural difficulties. These patients were flagged on the electronic records system and given priority appointments.

Hadleigh has a very small number of non-english speaking people, (over 95% white British). The practice had access to interpreting service if this were needed.

The practice worked with drug and alcohol services, prescribing for patients on a shared care agreement for patients with substance misuse.

People experiencing poor mental health (including people with dementia)

Good

The practice were part of a local initiative for being a dementia friendly town. They completed some refurbishment of the premises to make it easier for patients with dementia to orientate themselves within the building. They also took a proactive role in screening at risk patients for dementia. Each month a memory clinic was held at the practice with a GP and a consultant to diagnose patients with possible dementia.

A mental health link worker was based at the surgery once a week to see patients. Practice staff also liaised with the community mental health team for older people and drug and alcohol service.

Summary of findings

What people who use the service say

We spoke with eight patients as part of the inspection process and we received 16 CQC comments cards. All of the comments cards gave very positive feedback about the support patients had received.

Patients told us the practice offered an excellent service, staff were efficient, helpful and caring. They said they could get an appointment at a reasonable time, staff treated them with dignity and respect, always listened and explained information to them clearly.

Areas for improvement

Action the service SHOULD take to improve

The practice should record the relevant meetings to demonstrate that medicines incidents are monitored, trends are identified and action is taken to reduce any risk of reoccurrence.

The staff member with lead responsibility for infection control should receive additional training and protected time for the role.

The practice should review the arrangements for sharing and discussing changes in best practice guidelines with all relevant staff and the implications for the practice population.

The practice should review clinical meetings so that all clinical staff have regular opportunities to review clinical care and practice.

All non-clinical staff should receive annual appraisal.

The procedures for gaining patient consent to treatment should be audited.

Dr Flather & 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, a practice management advisor, a CQC medicines management inspector and an expert by experience.

Background to Dr Flather & Partners

Dr Flather and Partners is also known locally as the Hadleigh Boxford Practice Group. It provides services to approximately 14,900 registered patients in the Market town of Hadleigh and surrounding villages. It has one small branch surgery in the village of Boxford. The service is run by nine GP partners and provides an extensive range of services to the local community including support to three residential care homes, one nursing home and five homes supporting adults (and one for young people) with learning difficulties.

The practice employs one salaried GP, two nurse practitioners, four practice nurses, two health care assistants, a practice manager with two assistants, four secretaries and eight reception staff. The practice also runs its own pharmacy led by an employed pharmacist and eight dispensary staff. It is a training practice and supports trainee GPs and medical students. The practice is contracted to provide primary medical services.

This service was inspected as part of our routine comprehensive inspection programme and had not previously been inspected. We used the data we hold to identify potential risks areas to follow up as part of our inspection process.

During this inspection we visited Hadleigh Health Centre at Market Place, Hadleigh, Suffolk IP7 5DN. We also visited the dispensary at the branch surgery at Boxford Mill Surgery, Church Street, Boxford, Sudbury Suffolk CO10 5DU.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Harmoni.

Why we carried out this inspection

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

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

Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 31 March 2015.

During our visit we spoke with a range of staff including GPs, nurses, a health care assistant, reception staff, the practice manager and assistant practice manager, a pharmacist and dispensary staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We also collected the views of other patients through the completion of CQC comments cards, placed at the practice two weeks prior to our visit.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they reviewed and acted upon incidents and national patient safety alerts. They also responded to and took action following comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed incident reports and minutes of the weekly business meetings where safety issues were discussed. This showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the previous 12 months. Records we reviewed showed that 19 significant events had been reported during this time. Each significant event had been discussed at the weekly practice business meeting attended by the GPs and practice manager, and actions were agreed. This demonstrated that learning had taken place to improve practice although we found the learning was not always shared with the wider staff team.

As a result of a significant event analysis following an incident with a patient with mental health related issues the practice were able to share their learning with local services to help support improvements.

We did not see evidence that the practice completed checks to ensure that actions planned following significant events had been completed and were effective. The provider agreed this could be improved upon.

Staff knew how to raise an issue using the incident reporting system. The practice manager was responsible for managing and monitoring the incidents. We tracked some incidents and found that issues were dealt with in a timely manner. We saw evidence of action taken as a result of incidents. For example, where a prescription had been issued by a GP and sent to the dispensary without following the correct authorisation policy. All relevant staff had been reminded of the correct process so that prescriptions could be monitored accurately.

National patient safety alerts were disseminated by the practice manager to relevant practice staff. We found that medicines safety alerts were shared with the dispensary team as well as prescribers and appropriate action was taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. A GP had lead responsibility for monitoring all safeguarding concerns.

Training records showed that all staff had received relevant role specific training on safeguarding. Members of staff we spoke with were able to demonstrate they were knowledgeable in identifying and recognising possible signs of abuse in older people vulnerable adults and children.

Policies were in place for safeguarding children and adults at risk of abuse. These detailed how to deal with disclosures and reporting to the police and local authority. Details of staff with designated safeguarding responsibilities were known to staff. Local contact numbers of external partners such as social services were readily available and staff knew how to locate these if needed. The policies also dealt with sharing information and how to record concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The safeguarding lead was able to describe examples of concerns the practice had raised about vulnerable adults and how they had supported the investigation by the local authority to ensure the safety of vulnerable people.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All reception staff acted as a chaperone if

nursing staff were not available. They had completed training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

A whistleblowing policy was in place and accessible to staff for use if they wished to raise any concerns about poor practice.

Medicines management

We spent time talking to staff in the main dispensary and at the branch surgery. We observed that both dispensaries were well organised with appropriate staffing levels.

Policy and procedure folders were available in the dispensaries for staff to refer to about standard operating practices. We saw that procedures were updated regularly, and records showed that staff had read them.

Staff were aware prescriptions should be signed before being dispensed. In some circumstances prescriptions were not signed before they were dispensed but staff were able to demonstrate that a process was followed to minimise risk.

People were offered a choice of ways to request repeat prescriptions. Staff said if there were concerns they would be raised with the GP before the repeat prescription was issued. All prescriptions for Controlled Drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were issued by a doctor. The practice had a safe system for reviewing hospital discharge and outpatients' letters and making changes to medicines.

The practice provided a daily medicines delivery service to housebound patients, and the 'Dispensary Review of Use of Medicines' service was offered by telephone as well as in person, giving people who could not visit the dispensary access to this service.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that members of staff involved in the dispensing process were qualified and they had completed the appropriate mandatory training. Staff told us they had received on-going training and updating relating to dispensing and medicines management. Records to confirm that training had been completed were supplied to us following the inspection.

Errors in the supply of medicines to patients and 'near miss' errors were recorded. Staff told us, and records confirmed that individual incidents were reviewed and acted upon. The practice manager told us three partners met with the pharmacist each month. Incidents were discussed at this meeting and would be escalated to the main practice meeting if necessary. There were no records to support that medicines incidents were monitored so that trends could be identified and actioned.

National patient safety alerts relating to medicines were received by dispensary staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

There were arrangements in place for the security of the dispensaries so that they were only accessible to authorised staff. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held a small stock of Controlled Drugs for use in medical emergencies, and these were clearly recorded.

Cleanliness and infection control

The premises were visibly clean and tidy. The practice employed their own cleaning staff and cleaning schedules were in place that detailed daily, weekly and monthly cleaning tasks. We found that cleaning staff signed a record when they had completed cleaning in each area.

The assistant practice manager had daily contact with the cleaning supervisor and raised any issues or concerns on an informal basis. The practice manager had a system in place to complete daily checks around the premises. This included cleanliness checks although these were not recorded.

The practice had a lead member of staff to monitor infection control practice and advise colleagues on best practice. We found the member of staff had not received any additional training for the role and did not have protected time to complete any related duties. However they had completed an infection control audit with the practice manager and planned to continue with this on a quarterly basis.

Good

Are services safe?

An infection control policy and supporting procedures were available for staff reference. For example, the use of personal protective equipment and how to manage samples and specimens from patients safely when they were brought into the practice, Staff were able to describe how they followed these policies to meet safe infection control practice. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Fixtures and fittings such as flooring, seating and curtains were made of appropriate material for ease of cleaning.

The practice had procedures in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. A risk assessment had been completed by an external service within the last six months. We found the practice had taken action for example removing lime scale from taps and were continuing to complete other actions.

Equipment

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. Staff we spoke with told us they had suitable equipment to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

Staffing and recruitment

We looked at recruitment records and found they contained evidence that appropriate recruitment checks had been completed prior to employment. For example, proof of identification, references, qualifications and registration with the appropriate professional body. All clinical staff had criminal records checks through the Disclosure and Barring Service (DBS). Non- clinical staff with extended roles such as chaperoning and supporting baby clinics had also had DBS checks completed. The practice had a recruitment policy in place to guide them in recruiting clinical and non-clinical staff. Departmental leads were also involved in the recruitment process of their staff.

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

During discussions with staff we found that there were usually enough staff to maintain the smooth running of the practice. However, we found that recent changes to the nursing team meant they were not able to cover annual leave as easily and had little time to complete lead role responsibilities. The practice manager was aware of the impact of change and told us this was under review.

Monitoring safety and responding to risk

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

A range of risk assessments were in place and these were reviewed by the practice manager every six months. The risks considered included risks of staff experiencing violence in the workplace, the risk of injury from window blind cords and slips and trips hazards.

We saw that staff were able to respond to changing risks to patients or medical emergencies. For example the emergency system was activated for a patient in the car park outside. Staff also fast tracked a distressed infant from the waiting room to see a member of clinical staff.

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 equipment was

Good

Are services safe?

available and this included ready access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff were aware of the location of this emergency equipment and records confirmed that it was checked regularly.

There were systems in place that enabled staff to raise an alarm in an emergency situation either by phone or computer. This was used during the inspection to summon the help of staff for a patient arriving at the practice.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. These risks included power failure, adverse weather conditions, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to so that each risk could be addressed with external support such as the contractor responsible for the heating system in the event of a failure.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could describe the rationale for their approaches to treatment and were familiar with current best practice guidance. New guidelines issued from the National Institute for Health and Care Excellence (NICE) were received into the practice by email. The practice manager ensured these emails were forwarded on to each GP to incorporate into the practice. We found there was no regular process for discussing these at business meetings so that an awareness of changes effecting practice could be discussed and agreed.

The staff we spoke with and the evidence we reviewed confirmed that actions were designed to ensure that each patient received support to achieve the best health outcome for their individual need. Thorough assessments of patients' needs were completed by GPs and nurses and these were reviewed when appropriate. For example reviews for diabetic patients.

The GPs told us they lead in specialist clinical areas such as diabetes, respiratory disease and dementia. The practice nurses also supported the management of patients with long term conditions through providing specialist clinics to advise patients about staying healthy. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support on a day to day basis as required. This informal arrangement supported staff to continually review and discuss approaches to treatment. We found that clinical meetings could be improved so that all clinical staff have regular opportunities to review clinical care and best practice guidelines in a formal setting.

The practice held a register of patients who were vulnerable due to their complex health and well-being needs. This enabled them to discuss and continually assess their on-going needs at multidisciplinary meetings. Staff described that patients recently discharged from hospital were checked by a GP if they were identified as a vulnerable patient them so that up to date assessments could be completed.

GPs we spoke with used national standards for the referral of patients who required specialist hospital care for example in cases of patients with suspected cancer so that they were seen within two weeks. Referrals were reviewed and discussed at the weekly meetings as necessary.

During discussions and interviews with GPs and nurses we found the culture in the practice was that patients were cared for and treated based on need and the practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us six audits that had been undertaken in the last year. One audit on the collection of urine samples had led the practice to reconsider their policy on when to send urine samples for testing to the laboratory. As a result, new practice guidelines were developed to improve the use of resources and ensure that patient samples were tested appropriately so that treatments could be identified in a timely way. The guidelines were later adopted by the CCG (Clinical Commissioning Group). This is a group of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

Other examples of audits performed by the practice included audits of infection rates following minor operative procedures that identified only 1 infection in 67 cases of patients treated. An audit of visits showed a reduction in GP visits to care homes and nursing homes following the introduction of regular clinics held in each home by the nurse practitioner. We found that audits did not always follow a full audit cycle to assess whether changes to practice had made a significant or lasting difference.

The practice participated in the Quality and Outcomes Framework (QOF). This is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice used this information to monitor outcomes for patients and this was led by the practice manager and reviewed in the partners' meetings. We found that the practice was achieving the national clinical targets.

Staff we spoke with told us they had informal methods of discussing and reviewing clinical performance to improve

outcomes for patients. A business meeting took place on a weekly basis that routinely involved the GPs, the practice manager and their assistant. Other clinical staff such as the nurse practitioner or community nurses attended the meeting as needed, to reflect on outcomes for patients and review care and support they were delivering. Other regular meetings to review patient care included a monthly multidisciplinary team meeting and a separate monthly meeting to review palliative care patients. Records demonstrated that these meetings were productive, patient focused and actions were agreed.

There was a protocol in place for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines so that they could review use of the medicine to ensure it remained suitable for the patient's needs.

Data we held showed that the practice performance for prescribing medication such as antibiotics and some non-steroidal anti-inflammatory medicines was comparable to similar practices.

The practice had implemented the gold standards framework for end of life care. A palliative care register was in place to identify and monitor the needs of these patients and their families. Monthly records of meetings held by the lead GP for end of life care, Macmillan nurses and community teams demonstrated sympathetic and effective systems were established to provide appropriate care and support. The practice were pleased to report they were used as an exemplar of good practice by the local hospice at home team. In addition data we reviewed indicated the practice were providing above average support for palliative care in comparison to national averages.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending mandatory courses such as safeguarding adults and infection control. Online training was available to staff. The practice manager and their assistant checked and monitored this on a monthly basis to ensure all staff were keeping up to date. When staff were overdue for their training, reminders were sent to them.

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 appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). The assistant manager had responsibility for checking the nurses' registration with the Nursing and Midwifery Council (NMC) was renewed every year. The NMC is the professional body that holds the licenses for all nurses and midwives.

Some staff had an annual appraisal completed that identified learning needs from which action plans for their training and development were documented. However, administrative staff including the practice manager and assistant practice manager had not had an appraisal completed for more than five years. The practice told us they had identified this need and had a planned meeting to decide on how best to take this forward.

Our discussions with staff confirmed they received support for training and that relevant courses were funded. For example a nurse had been supported to develop her skills and role as a nurse practitioner. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

The nursing team were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, the health care assistant provided a venepuncture service for taking patients' blood tests. Practice nurses updated their skills for example to enable them to perform cervical smears and the administration of vaccines and childhood immunisations. Data showed the practice achieved a high level of uptake for childhood immunisations.

Working with colleagues and other services

The practice worked with other health care services to meet patients' needs, especially for the needs of patients with complex requirements. There were systems in place to receive information such as blood test results, X ray results,

Good

Are services effective?

(for example, treatment is effective)

and letters from the local hospital including discharge summaries either by post or electronically. There were further systems to ensure information was exchanged with the out-of-hours GP services and the 111 service so that patients who had received their support continued to be cared for by the practice in accordance with their needs.

The information was passed to the relevant GP who reviewed these documents or results and took responsibility for taking any action required. If a GP was unavailable, a buddy system was in place to ensure that results were checked and action was taken in a timely way. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings each month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, physiotherapists and occupational therapists. We also noted that Age UK representatives had also participated to support reviews of appropriate patients. In addition, many informal discussions were possible because other community teams were based within the practice building. Staff felt this helped to develop good relationships and communication systems to enhance patient care.

We spoke with key staff in three care homes and one nursing home. They spoke very positively about the support they received from staff at the practice. They told us that regular weekly visits from the nurse practitioner had been very effective in helping staff to support the health and well being of people who lived in the homes. They were also able to receive timely GP visits for patients with more complex health needs.

Information sharing

The practice used several electronic systems to communicate with other providers. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals including through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record known as SystmOne to coordinate, document and manage patients' care. All staff were fully trained on the system which had been in use since 2014. Staff commented positively about the system's safety and ease of use which enabled paper communications to be scanned into patients electronic records, such as those from hospital, and saved for future reference.

Consent to care and treatment

Patients at the end of life were supported to make advance care plans so that staff were able to support their decisions about treatment and how they wished to be cared for if they were unable to communicate their needs.

There was a practice policy for documenting consent for treatments and procedures (last reviewed February 2015). This included how to ensure that a patient had a clear understanding to make an informed decision. It covered principles of consent for children and young people and referred staff to the consideration of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). We noted it did not refer to the Mental Capacity Act although it guided staff to involve carers or advocates supporting a patient to find appropriate ways to ensure that patients had a sufficient understanding of the procedure to give their informed consent.

The practice could not demonstrate that a consent audit had been completed.

The nurse practitioner worked with staff at the local residential and nursing homes for older people and used the Mental Capacity Act toolkit to support older patients to make decisions for themselves as far as possible. Both she and the practice manager confirmed their understanding of this. They were familiar with the process required for making best interest decisions and working with other health and care professionals to support the patient who was unable to consent to key decisions.

Health promotion and prevention

Good

Are services effective?

(for example, treatment is effective)

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. Clinical staff described how they used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. If a patient was found to have any risk factors for disease identified at the health check, they were advised to have further investigations.

The practice were pro-active in identifying patients with health and care needs and offering additional help. For example, the practice kept a register of all patients with a learning disability and offered an annual physical health check. Data we checked indicated the practice completed a high number of annual health reviews for this group of patients in comparison to national averages. The pharmacist employed by the practice worked jointly with the nurse practitioner to complete medication reviews for patients in the four care/nursing homes that were supported by the practice.

There was a policy in place to offer telephone reminders for patients who did not attend for health screening appointments such as cervical smears and the practice audited patients who do not attend. There was also a named member of staff responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards which were all very positive about the service patients had experienced. Patients told us that staff were professional, helpful and caring. We also spoke with eight patients on the day of our inspection. All of the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Staff routinely used measures to promote patients' privacy for example by using disposable privacy curtains in consulting and treatment rooms during examinations, investigations and treatments. We also found that staff closed the doors of consultation / treatment rooms so that conversations could not be overheard by others.

The practice switchboard was located away from a public area of the practice so that patient information could be discussed in private. During the last national patient survey, feedback identified patient concerns about privacy at the reception desk. In response to this, the practice had introduced a system to allow only one patient at a time to approach the reception desk. This helped to limit conversations being overheard.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

We also spoke with a patient from a vulnerable group who was being supported in attending the practice by a carer. They both told us that the staff treated them with care and empathy and praised their welcoming attitude.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded 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. For example, data from the NHS England national patient survey showed 93.4% of practice respondents said the GP involved them in care decisions and 97% rated their overall experience of visiting their GP service as good or very good. Both these results scored higher than national average scores.

Patients we spoke with on the day of our inspection told us that clinical staff discussed their health needs so that they were involved in decision making about the care or treatment they received. They also told us they felt listened to and supported by staff so they understood their treatment choices and were able to make an informed decision about their treatment. These issues also scored above national averages for the last NHS England patient survey.

Staff told us that translation services were available for patients who did not have English as a first language. 95% of registered patients at the practice were English and staff reported they had not needed to use this service.

The practice worked closely with the hospice at home team to ensure that patients at the end of their life receive care and support to reflect their individual needs and choices. This included the use of advance care plans so that patients could discuss their care needs and how they wished to be cared for before they become too unwell to do so.

Patient/carer support to cope emotionally with care and treatment

The NHS England national survey information showed that patients were positive about the emotional support provided by the practice and rated it above average in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, patients said that staff were easy to talk to, listened to them and provided them with follow up support when required.

Information held in the reception, on the TV screen and patient website also told patients how to access a number of support groups and organisations. Staff described that the practice's computer system alerted GPs if a patient was also a carer so that staff could assess their needs for support on an on-going basis.

When a patient registered with the practice died, their families were contacted by their usual GP and offered

Good

Are services caring?

a bereavement visit or appointment at the practice depending upon their needs. This included advice on how to find a support service if they wanted it. A patient we spoke with confirmed this type of support was offered.

We found the practice were involved in a local initiative with the church to support people through the grieving and bereavement process.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and the practice took steps to work with the local community to identify needs and respond to them.

Information we received from the NHS England Area Team and Clinical Commissioning Group (CCG) showed the practice engaged regularly with them and other practices to discuss local needs and prioritise service improvements. For example they shared the work they completed to ensure that patient urine samples were tested in a timely and appropriate way.

The practice implemented changes to improve the service in consultation with the patient participation group (PPG). For example they reviewed the colours used on the television information screens in the waiting areas so that patients with poor vision could read them more easily. They were also consulted about the concerns patients had raised about privacy in the waiting room so that changes could be implemented.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. We found they had completed a home visit audit to review the needs of older people living in four local nursing/residential homes. This led to the introduction of weekly visits by the nurse practitioner who was able to treat minor illnesses and provide advice about the health and well-being of the patients. This resulted in greater continuity of care and a proactive approach to their health needs.

The practice had access to online and telephone translation services if this was required.

The practice staff had access to equality and diversity training through e-learning. Records indicated that most staff had completed this in the last 12 months. The practice manager had a system in place to monitor outstanding training to ensure staff completed the expected training.

The practice was situated on two levels of the building with most services for patients on the first floor. The premises and services had been adapted to meet the needs of patient with disabilities. There was a hearing loop on each floor of the premises. A low level section on the reception desk improved access and communication for patients who use a wheelchair. A lift was available for patients with limited mobility. Notices on the television screen in reception had been changed to suitable colours to help patients with visual impairment to read them more easily.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had signed up to a local initiative for being a dementia friendly town. They had completed some refurbishment of the premises to make it easier for patients with dementia to orientate themselves within the building.

The practice had a population of 95% English speaking patients though it could cater for other different languages through a translation service.

Access to the service

Appointments were available at Hadleigh Health Centre from 8.30- 6.00 pm weekdays with extended opening hours 7.00- 8.00 am Monday to Thursday. Between the hours of 12.00 and 3.00 pm no bookable appointments were available with the GPs although some appointments were available with the practice nurses. The branch surgery in Boxford opened at the same times with the exception of Wednesday afternoons when there was no GP available.

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

The practice provided 10 minute appointments but these could be extended for patients with more complex needs. Telephone consultations were available for each GP on a daily basis. Home visits were made to four local care homes

Good

Are services responsive to people's needs?

(for example, to feedback?)

on specific days each week, by the nurse practitioner. A named GP provided visits to the homes if they required further assessment. Home visits were provided by a GP to those patients who were housebound.

Patients were generally satisfied with the appointments system and told us they received appointment reminders by phone and email. They confirmed that they could usually see a doctor on the same day if they needed to and this was often their preferred GP. They were also able to book up to six weeks in advance for routine appointments.

Priority booking was given to babies and infants and other vulnerable groups such as patients with mental health conditions and young adults with behavioural difficulties who were being supported by a local specialist service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice manager was the person who handled all complaints in the practice. A record of all written and verbal complaints was kept. This included details of the responses given to people who had raised the complaint and a summary of the investigation and outcome. Responses to complaints had been provided in a timely manner. The practice did not complete an annual review of complaints received to identify any issues or trends that could be act upon to improve the service further.

The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information about making a complaint had been reviewed by the practice in response to the patient survey. The complaints leaflet had been reviewed and circulated in the reception areas. Information on the practice website had also been updated.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a business plan in place dated September 2014. This set out the aims to deliver high quality care and promote good outcomes for patients. A mission statement was part of the overall plan and this was produced by the partners and management team. The plan was short term covering no further than two years ahead. The management team told us this was due to imminent senior staff changes and the changing NHS and political environment. The practice's vision and values included being courteous, approachable, friendly and helpful and to strive for continuous improvement of patient services.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 7 policies and procedures and found they had been reviewed annually and were up to date. Staff were aware of how to locate the policies and policies were a key part of the induction programme for new staff.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and lead GP for safeguarding. Members of staff we spoke with told us they were all clear about their own roles, they felt valued and well supported by their peers and managers.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at business meetings and action plans were agreed to maintain or improve outcomes.

The GPs attended local peer review meetings and networked with other GPs to help benchmark their practice with others.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example regular audits of controlled drug prescribing took place to look for unusual products, quantities, dose, formulations and strength. Outcomes were shared with the GP prescribers for action.

The practice had arrangements for identifying, recording and managing risks. This included through management and monitoring of significant events, complaints and feedback. Although they did not maintain an overall risk log, we saw that issues were raised and considered at the business meetings and partners meetings. Risk assessments had been carried out where risks were identified and suitable controls were in place. This included, for example the risk of staff experiencing violence at work and detailed actions to reduce this risk.

The practice held weekly business meetings that included regular agenda items such as significant events/incidents, information governance and complaints. However they were not regularly attended by nursing staff or department leads. Monthly multidisciplinary meetings and palliative care meetings took place monthly but other staff meetings occurred on an 'as required basis'. Informal communication systems meant there was a risk that key messages in relation to quality improvements were not always shared with the wider team.

Leadership, openness and transparency

The practice did not hold regular staff team meetings and said that the partners and the nurses held meetings on an as required basis. Staff told us that there was an open culture within the practice and informal communication and teamwork was good. The practice manager told us the CCG were supporting the practice to introduce a half day each month to address training for the practice team or to use for staff meetings and peer support sessions. This would start in April 2015.

The deputy practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, (for example disciplinary procedures, induction policy, management of sickness) which were in place to support staff. We were shown the electronic staff handbook that 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.

Seeking and acting on feedback from patients, public and staff

Are services well-led?

Good

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

The practice had gathered feedback from patients through comment cards, complaints and patient surveys. We looked at the results of the annual patient survey where 38% of patients said that they did not know how to complain if they needed to. We saw as a result of this the practice had reviewed the information provided to patients on how to raise complaints and ensured this was accessible to them.

The practice produced a quarterly newsletter for patients. This included feedback on surveys and suggestions raised by the patients so that they were aware of any actions being taken.

The practice had a virtual patient participation group (PPG) with a well-established membership of 14 patients. The group did not have face to face meetings but communicated with each other and the deputy practice manager by email. The PPG had been involved in developing the patient survey and commenting on the analysis and action plans. One member told us that comments about patients' experience of using the service were shared by email with the practice. They always received a response back so they could in turn, inform the individual patient of the response. They told us that patients were very happy with access to the service and the booking system.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues or the management. They told us that they felt they were listened to and enjoyed the jobs.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We found that clinical staff received regular appraisals although this was not routinely in place for other non-clinical staff. Staff told us that they completed online training programmes and that the practice was very supportive of external training. Recently the Clinical Commissioning Group (CCG) had agreed to support monthly half days to enable staff to hold team development meetings or attend training.