Framfield House Surgery

Quality Report

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

Ratings

Overall rating for this service	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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Framfield House Surgery on 11 August 2016. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns
- Patients said they found it easy to make an appointment with a named GP and 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.
- The practice had strong and visible clinical and managerial leadership and governance arrangements. Staff felt supported by management and the practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) performance at this practice was in line with or better than other practices within the CCG and nationally. However exception reporting rates were higher than average for some QOF indicators.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey 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 decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.
- Results from the national GP patient survey published July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was in-line for its satisfaction scores on consultations with GPs and nurses. For example:

1. 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
2. 87% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
3. 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice provided rooms at the practice for specialist consultations where possible to prevent patients travelling to local hospitals and clinics. These included health visitors, midwives, district nurses who ran leg ulcer clinics at the practice, Improving Access to Psychological Services (IAPT), Suffolk Family Carers, NHS Podiatry, NHS speech and language services, NHS physiotherapists, Cardiology, ultrasound and tele–derm clinics and the citizens advice bureau.
- The practice hosted a number of private providers from the practice to enlarge the service provided. These included a clinical psychologist specialising in children and families, physiotherapy, osteopathy, counselling and hearing services.
- The practice had set up and funded an exercise on referral scheme where patients received six free small group sessions from a personal trainer at an outside gym.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. All of the 32 patient Care Quality Commission comment cards we received were positive about the service experienced. However three cards raised

Summary of findings

comments regarding continuity of GPs and the appointment system. One card noted things were improving. Patients said they felt the practice offered an excellent service and staff were professional, helpful, caring and treated them with dignity and respect.

- The practice ran personal lists and GPs saw their own patients where possible to provide continuity of care. All patients with urgent problems were seen on the same day, however not necessarily by their own GP.
- 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 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.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- 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 governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. All home visits were triaged by a clinician to prioritise visits and ensure appropriate and timely intervention.
- The practice would contact all patients after their discharge from hospital to address any concerns and assess if the patient needed GP involvement at that time.
- The practice offered health checks for patients aged over 75.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis and heart failure, were above local and national averages.
- The practice was part of the Deben Health Group and worked in cooperation with local practices in providing care plans for vulnerable and/or patients with complex needs at risk of hospital admission. The practice was a teaching and training practice working in cooperation with other practices from the Deben Health Group.
- The practice provided weekly and as required medical services by named GPs to five local care homes.
- The practice provided a delivery service for medicines for those patients who were housebound.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was better in comparison to CCG and the national average with the practice achieving 99% across each indicator, eight percentage points above CCG averages and ten percentage points above national averages. However the rate of exception reporting for some indicators was higher than both CCG and national average. For example; the percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria)

or micro-albuminuria who were treated with an ACE-I (or ARBs) exception reporting was 15%, this was six percentage points above the CCG average and seven percentage points above the national average.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Flu vaccination rates for the 2015 to 2016 flu campaign for the over 65s were 75%, and at risk groups 93%.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 98%, which was comparable to the CCG average of 95% to 98% and five year olds from 94% to 99%, which was comparable to the CCG average of 93% to 97%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 76% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses. The practice provided additional services for young people through its relationship with a local boarding school. The practice provided medical services through weekly term time clinics and annual health checks for boarding students. The practice liaised with the

Summary of findings

school nurse as well as providing training events for teaching staff, such as anaphylaxis training and sexual health talks for students. The practice had written and implemented a policy for the school concerning the outbreak of infectious diseases in a school community.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, 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 and screening that reflects the needs for this age group.
- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Figures published by Public Health England show that 66% of the practice's target population were screened for bowel cancer in 2014/2015 which was above the national average of 58%. The same dataset showed that 82% of the practice's target population were screened for breast cancer in the same period, compared with the national screening rate of 72%.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care 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 a learning disability.
- The practice had identified 37 patients with a learning disability on the practice register, 34 had been offered a health check and 30 had received a health check in the previous 12 months. The remaining four patients were scheduled appointments. The practice provided one hour appointments for patients for a learning disability review.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- Performance for mental health related indicators was better in comparison to CCG and the national average with the practice achieving 97% across each indicator, six percentage points above CCG and four percentage points above national averages. However the rate of exception reporting for some indicators was higher than both CCG and national average. For example; the percentage of patients on lithium therapy with a record of lithium levels recorded in the preceding four months, exception reporting was 20%, this was ten percentage points above the CCG average and eleven percentage points above the national average.
- The practice had identified 101 patients on the mental health register of which all had been invited to attend for an annual health check on their month of birth with 82 attending for review in the previous 12 months. The practice continued to encourage attendance for review and patients were contacted by text or letter and then by telephone if they do not respond. Of the 95 patients on the practice dementia register 69 patients had attended for a health check in the previous 12 months.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice provided weekly and as required medical services by named GPs to patients with a diagnosis of dementia that lived in two local nursing homes.

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- The practice facilitated weekly clinics held by the Improving Access to Psychological services (IAPT) and the Community Mental Health Team (CMHT). We were told this enabled the support of patients who needed step up/step down care, in addition this ensured support to patients whose diagnosis or referral pathway was unclear.
- The practice also facilitated a number of outreach services as needed for those patients who were unable to travel to clinics. These included a clinical psychologist specialising in children and families.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice was performing in line with local and national averages. 219 survey forms were distributed and 126 were returned. This represented a 58% response rate.

- 90% of patients found it easy to get through to this practice by phone compared to the CCG average of 82% and the national average of 73%.
- 67% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 82% and the national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the CCG average of 88% and the national average of 85%.
- 79% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 83% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. All of the 32 patient Care Quality Commission comment cards we received were positive about the service experienced. However three cards raised comments regarding continuity of GPs and the appointment system. One card noted things were improving. Patients said they felt the practice offered an excellent service and staff were professional, helpful, caring and treated them with dignity and respect.

Patients we spoke with told us they felt the practice offered a good service and that staff were helpful, compassionate and treated them in a respectful manner. However some patients commented that it wasn't always possible to see their own GP.

Framfield House Surgery

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 adviser and a practice manager specialist adviser.

Background to Framfield House Surgery

Framfield House Surgery is located in Woodbridge, Suffolk. The practice is run by a partnership of four GPs (three female and one male). The practice employs three female and one male salaried GP, three female advanced nurse practitioners, three female practice nurses and four health care assistants. The clinical team is supported by a practice manager, a deputy practice manager, an operations manager and a practice accounts administrator. There is a team of administrative and reception staff and medical secretaries. The practice is a training practice with one associate GP trainer. The practice dispenses to around 3,000 patients and a team of dispensers work alongside the Waterton pharmacy staff, having achieved National Vocational Qualifications (NVQ) in Dispensing Services to ensure they are competent to a minimum standard equivalent to NVQ level 2 in Pharmacy Services.

The registered practice population of 11,976 are predominantly of white British background, and. the practice deprivation score is low compared with the rest of the country. According to Public Health England information, the practice age profile has higher percentages of patients over 45 to 85+ years compared to the practice average across England. It has lower percentages of patients between the ages of 20 to 44 years.

The practice is open between 8am and 6.30 Monday to Friday. Appointments are from 8.20am to 11.30am every morning and 3.30pm to 5.30pm daily. Appointments with other clinicians are available from 8am to 6.30 daily. Extended hours appointments are offered from 6.30pm to 8pm Tuesday evenings, 7.30am to 8am Wednesday mornings and from 8:30am to 12:30pm on one Saturday each month. In addition to pre-bookable appointments that can be booked up to six weeks in advance, urgent appointments are also available for people that need them. The pharmacy opening times are from 8am to 7.30pm Monday to Friday, 9am to 1pm Saturday and 10am to 12 noon Sunday. The practice takes part in the Suffolk Federation GP+ scheme which offers routine appointments outside of opening hours. The practice is able to book appointments for patients with this service.

The practice holds a Personal Medical Service (PMS) contract to provide GP services which is commissioned by NHS England. A PMS contract is a nationally negotiated contract to provide care to patients. The practice offers a range of enhanced services commissioned by their local CCG: including improving patient on-line access, extended hours access and support for people with dementia. The practice is a teaching and training practice working in cooperation with other practices from the Deben Health Group.

Out of hours care is provided via the NHS 111 service.

Why we carried out this inspection

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. The 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.

How we carried out this inspection

Before visiting, 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 visit on11 August 2016. During our visit we:

- Spoke with a range of staff (GPs, nursing staff, management teams, reception, administration, pharmacy and dispensing staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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 were provided for specific groups of people and what good care looked 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).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- There was a nominated safeguarding GP lead. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). There was a significant event lead who described to us how they would write to each member of staff who raised a significant event to ensure they were aware of the outcome. Where issues had been identified these were also addressed with the team leaders. Significant events and learning outcomes were also disseminated to all staff at team meetings.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information and were told about any actions to improve processes to prevent the same thing happening again.
- The practice discussed significant events at weekly partnership meetings and carried out a thorough analysis of each significant event.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were received by the pharmacy/dispensary and immediately acted upon. (This is a government agency which approves and licenses medicines, allowing them to be prescribed in the UK. The principal aim of the agency is to safeguard the public's health). The MHRA alert was signed dated and a copy forwarded to Framfield Surgery management team. The MHRA alert was then kept by the pharmacy/dispensary for future monitoring and shared learning.

We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following an incident of a patient collapsing in the adjoining pharmacy/dispensary the practice reviewed its incident policy and put systems in place during the weeks that followed to ensure patients safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were detailed and updated contact lists on staff notice boards to assist staff when knowing who they should contact. There was a lead member of staff and deputy member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level 3. The practice also ensured that systems were in place to link complex families. During a whole practice meeting in October 2015 the safeguarding lead had undertaken training with all staff on safeguarding children. All staff were given the opportunity to suggest improvements; an outcome of this was the following up of all children who did not attend their hospital appointments. This had led to the practice now following up all patients who did not attend their hospital appointment.
- A notice in the waiting room advised patients that chaperones were available if required. Nurses who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A member of the nursing team was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any

improvements identified as a result. There was a rolling schedule of work that required undertaking. For example, the installation of elbow taps in all clinical rooms.

- We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Medicines Management.

Framfield House dispensary was located within Waterton Pharmacy. They shared resources such as a pharmacist and standard operating procedures. The dispensary dispensed medicines to patients who were entitled and lived in the local villages. Some of the dispensary staff worked across both organisations and appropriate information sharing agreements were in place to ensure that patients and their information were managed safely. Dispensing staff were qualified to NVQ2 level. And an honorary agreement (a contract issued to authorised workers who are paid by another non-NHS organisation and whose employment remains with that other organisation) was in place. This allowed authorised personnel to access certain areas of the patients' medical records in order to ascertain whether any appropriate and necessary tests had been completed prior to the dispensing of certain medications, such as warfarin (an anticoagulant used to prevent blood from clotting) and methotrexate, (used to treat certain types of cancer, severe psoriasis and rheumatoid arthritis). These personnel were able to access hospital and out of hours records, and, in the event that medication had been initiated or changed through these services, were able to confirm with the GPs prior to the dispensing of medicines.

The patients benefited from the pharmacy/dispensary opening hours and were able to collect their medicines on Monday to Friday 8am to 7.30 pm, Saturday 9am to 1pm and Sunday 10am to 12 noon. The practice had signed up to the Dispensing Services Quality Scheme (DSQS) which rewards practices for providing high quality services to patients of their dispensary. As part of this scheme the practice had to ensure that face to face reviews with 10% of patients are carried out to assess compliance and understanding of the medicines being prescribed. During the inspection it was confirmed by the partners that the relevant number of reviews were being carried out appropriately.

The dispensary was secure at all times and access was restricted to authorised personnel only. The dispensary held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and there were procedures in place to manage them safely. There was also a procedure for the destruction of controlled drugs and the relevant paperwork was completed and signed as required. Controlled drugs were kept in a locked cabinet and regular fortnightly stock checks were made by a pharmacist and dispenser. Only authorised personnel were able to access the controlled drugs cabinet.

There was pharmaceutical refrigerator for the storage of medicines which needed to be kept at low temperatures. This was secure and records were kept ensuring that the required temperatures were being monitored. Medicines were stored securely and in a temperature controlled, clean and tidy environment and the medicines we checked were within their expiry date. The practice had a process by which dispensary staff were able to immediately order supplies as soon as stocks were becoming low.

All prescriptions were signed by a GP prior to medication being dispensed. The staff demonstrated a good checking procedure, this ensured that all processes were completed appropriately reducing the possibility of any errors being made. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. In the event of the pharmacy superintendent being away from the pharmacy/dispensary, a system was in place whereby another regular pharmacist or locum pharmacist would take over the running of the pharmacy/dispensary.

Both the pharmacy and dispensary evidenced their standard operating procedures (SOPS) which were dated and signed by all appropriate staff were in place. (These are practice specific written instructions about how to dispense medicines safely). For example. The practice offered a medicine delivery service and procedures were in place for this service which benefited those patients who were housebound.

Good

Are services safe?

Dispensary staff had received annual appraisals and ongoing training, such as basic life support training and fire training. There was a lead GP responsible for the dispensary and they had weekly meetings with the pharmacy superintendent to discuss issues relating to dispensing procedures, policies, concerns or incidents. Appropriate records were kept of any 'near misses' and actions taken. These were discussed on a regular basis with the dispensing staff and also the practice team. A procedure was in place for the recording of significant events (a process used to show quality improvement and learning process in the event of a significant occurrence either beneficial or deleterious). Staff were aware of how to record and share a significant event and the learning outcomes.

There was an audit trail for all medications used in the practice including those required for the GP bags. There was a system to check the GP bags monthly. Blank prescriptions were securely stored and were logged on receipt and their use monitored. Prescription for collection at other pharmacies were logged and signed for on collection. The practice dispensed weekly packs for people who needed support to manage their medicines.

There was a private area available in which patients could discuss any areas of concern or queries. There was good communication between the pharmacy/ dispensary and the GPs, and changes to medication was always checked with a GP before dispensing. The practice paid for a home deliveries service of medicines from the dispensary and pharmacy from Monday to Friday for patients unable to attend the practice.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice were forming close working relationships with the Deben Health Group to share resources, knowledge and skills.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were within their expiry date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. The practice used regular weekly educational meetings to review and train staff on new NICE guidelines. All clinical staff were given the opportunity to attend monthly CCG educational meetings and were paid to attend if this was in their own time.
- The practice monitored that these guidelines were followed through risk assessments, an informed programme of audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99% of the total number of points available. With 11% exception reporting rate, (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects) this was 3 percentage points above CCG average and 2 percentage points above national averages.

Performance at this practice was in line with or better than other practices within the CCG and nationally. However exception reporting rates were higher than average for some QOF indicators. Data from 2014/15 showed:

- Performance for asthma, atrial fibrillation, cancer, chronic obstructive pulmonary disease, depression, dementia, epilepsy, heart failure, learning disabilities, osteoporosis, palliative are, peripheral arterial disease, rheumatoid arthritis, secondary prevention of coronary heart disease and stroke and transient ischaemic attack were all in-line or above CCG and national averages with the practice achieving 100% across each indicator.
- Performance for diabetes related indicators was also better in comparison to CCG and the national average with the practice achieving 99% across each indicator, eight percentage points above CCG averages and ten percentage points above national averages. However the rate of exception reporting for some indicators was higher than both CCG and national average. For example; the percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who were treated with an ACE-I (or ARBs) exception reporting was 15%, this was six percentage points above the CCG average and seven percentage points above the national average.

We discussed the areas of higher rates of exception reporting for the QOF year 2014/2015 with the practice, the practice had an ethos to not except patients from QOF, we were told where certain recommended treatments were not appropriate the practice would except the patient from the indicator.

The practice told us that, as the total numbers of patients on these long term condition registers were small and the numbers of patients who the practice exception reported were also small, this would account for areas where exception reporting appeared as a high percentage in comparison to local and national averages. We were assured that the practice continued to encourage attendance from these patients for health and medication reviews to ensure they were not overlooked.

Clinical audits had been completed in the last year; there were completed audits where the improvements made were implemented and monitored. These included completed audits on high risk medicines monitoring, dispensing errors, prescribing audits, inadequate cervical smear audits, minor surgery audits, quality control of phlebotomy audits and antibiotic prescribing. An audit of blood samples taken in May 2016 evidenced two inadequate samples taken in this period. The practice explored the reasons for this and had updated the phlebotomy protocol with a planned re-run of this audit in November 2016. In 2015 the practice had undertaken an audit on the repeat prescribing of non–steroidal

anti-inflammatory (NSAID) medicines. These medicines are used to relieve pain and reduce inflammation. The second cycle of this audit in 2016 showed that ten patients had not requested a repeat prescription for this medicine for six months. These were stopped as a repeat prescription, other patients were found to be appropriately prescribed this medicine either by the practice or under the care of a rheumatology consultant. The remaining patients had a note added to their computer screen to ensure they were invited in for a medicine review prior to their next repeat prescription with a maximum of one issue prior to review. The practice planned to re-run this audit in a further six months to ensure that patients were only taking NSAIDS where this was beneficial to them.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example clinical and safety alerts were disseminated to all clinicians. These were printed as well as sent electronically and all clinicians signed to say they had seen them. One GP reviewed all alerts to establish if any action was necessary and alerted the other clinicians. Actions were then audited and re-audited to ensure that recommended actions had been completed.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, fire safety, health and safety and confidentiality. For example the practice was a training practice with one associate GP trainer; we saw the comprehensive induction programme to meet the needs of the new trainee. This included 30 minute appointments to see patients and protected supervision time with the GP to discuss and review all the patients that they had seen. The practice also provided placements for medical students. The practice showed us the planned timetable for teaching sessions, and practice staff were aware that patient consent must be obtained before they were seen by students or for joint consultations with GPs. The practice had supported a practice nurse to undertake training to become a nurse practitioner.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings, and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. Practice staff had received an appraisal within the last 12 months. The practice held weekly education meetings where the latest guidance, training and alerts were reviewed and discussed.
- The practice had oversight and staff received training that included safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. For example, the practice medical secretaries used a template which enabled them to turnaround all referral letters within 24 hours. The practice had made changes to the practice protocols for vulnerable children as a result of a team meeting on safeguarding in October 2015. As a result the secretaries had added the GP screening tool for children

Good

Are services effective?

(for example, treatment is effective)

and young people to the referral template. This was available on the practice notice boards however the secretarial team felt the tool provided an additional safeguarding to assess risk.

- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Following staff input the practice followed up all patients who did not attend for their hospital appointment to identify any vulnerable patients.
- Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. GPs met monthly with health visitors to discuss children of concern, information was documented directly onto patients' records. The health visitors worked from the practice site which enabled easy liaising and communication between the services.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. There was a GP lead for mental capacity and deprivation of liberty (DOL), who had undertaken training, provided staff training and acted as a resource for staff to approach with any queries. For example about assessing capacity. Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. The practice computer system had been set up to ensure a pop up for all patients under 16 years appeared during their consultation to prompt clinicians to ensure they assessed the young person's capacity where required.
- The practice had introduced a section on the new patient registration form to identify parental responsibility for infants and children when new patients joined the practice.
- GPs had responsibility for each care home in the practice area. One GP, for the home they were responsible for had ensured the practice had a list of all the patients who had a deprivation of liberty (DOLS) assessment in place and that it was noted on the patient records. They had ensured staff understood that the coroner must be notified in the event of a patient's death. The staff had received training and told us that they had found this useful. The GP told us that they planned to ensure that all GPs were doing this for the homes they were responsible for.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example: patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking, drug and alcohol cessation. Information was available in the practice waiting room area and from reception. Patients were also signposted to the relevant service.

The practice's uptake for the cervical screening programme was 80%, which was comparable to the CCG average of 76% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Figures published by Public Health England show that 66% of the practice's target population were screened for bowel cancer in 2014/2015 which was above the national average of 58%. The same dataset showed that 82% of the practice's target population were screened for breast cancer in the same period, compared with the national screening rate of 72%.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to

Good

Are services effective?

(for example, treatment is effective)

under two year olds ranged from 96% to 98%, which was comparable to the CCG average of 95% to 98% and five year olds from 94% to 99%, which was comparable to the CCG average of 93% to 97%. Flu vaccination rates for the 2015 to 2016 flu campaign for the over 65s were 75%, and at risk groups 93%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74, 407 health checks had been undertaken in the previous year. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. The practice referred patients to various support services.

The practice had identified 37 patients with a learning disability on the practice register, 34 had been offered a health check and 30 had received a health check. The remaining four patients were scheduled appointments. The practice provided one hour appointments for patients for a learning disability review.

The practice had identified 101 patients on the mental health register; all had been invited to attend for an annual health check during their birthday month with 82 patients attending for review in the previous 12 months. The practice continued to encourage attendance for review and patients were contacted by text or letter and telephone. Of the 95 patients on the practice dementia register 69 patients had attended for a health check in the previous 12 months.

The practice had developed a self-referral exercise programme. The practice had identified a personal trainer who was sponsored by the practice with advertising and information. Patients could self-refer to the trainer and received six one hour sessions. This was to provide patients with healthy living, lifestyle choices and health promotion advice to prevent then developing conditions such as heart disease or diabetes. The practice facilitated rooms for a physiotherapy service and patients were also able to self-refer to this service. Information was also available at the practice for health and wellbeing tips for teenagers and a local walking for health groups.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 32 patient Care Quality Commission comment cards we received were positive about the service experienced. However three cards raised comments regarding continuity of GPs and the appointment system. One card noted things were improving. Patients said they felt the practice offered an excellent service and staff were professional, helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was in-line for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 86% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey published July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 85% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in other languages such as Chinese and Portuguese and in an easy read format.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 230 patients as carers (1.9% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice offered extended hours appointments on a Tuesday evening until 8 pm and one Saturday morning per month this benefited working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available. Same day appointments were available for children and those that needed them.
- The practice oversaw the care of patients in one nursing home and several residential homes. There was a lead GP for the nursing home and another GP for the residential homes. The practice ensured there was protected time each week for these GPs to provide support proactive care to these homes.
- The practice provided a range of nurse-led services including minor illness clinics, leg ulcer treatment and dressings, phlebotomy services, audiology services, immunisations, shingles, flu and pneumococcal vaccinations and family planning.
- Baby clinics were scheduled at quieter times, to ensure parents with children plus other patients received a calmer and more sensitive approach to their appointment time.
- Appointments for patients with learning disabilities were scheduled away from other patients in a quiet environment at a quiet time of day to provide a sensitive and calmer environment.
- There was a named GP for all patients including families.
- The practice could refer patients to a range of services including mental health support groups and charities, Improving Access to Psychological services (IAPT) and the Community Mental Health Team (CMHT).
- The practice provided rooms at the practice for specialist consultations where possible to prevent patients travelling to local hospitals and clinics. These included health visitors, midwives, district nurses who ran leg ulcer clinics at the practice, Improving Access to Psychological Services (IAPT), Suffolk Family Carers, NHS Podiatry, NHS speech and language services, NHS physiotherapists, Cardiology, ultrasound and tele – derm clinics and the citizen's advice bureau.
- In addition the practice hosted a number of private providers from the practice to enlarge the service provided. These included a clinical psychologist specialising in children and families, physiotherapy, osteopathy, counselling and hearing services.
- The practice had set up and funded an exercise on referral scheme where patients received six free small group sessions from a personal trainer at an outside gym.
- The practice provided additional services for young people through its relationship with a local boarding school. The practice provided medical services through weekly term time clinics and annual health checks for boarding students. The practice liaised with the school nurse as well as providing training events for teaching staff, such as anaphylaxis training and sexual health talks for students. The practice had written and implemented a policy for the school concerning the outbreak of infectious diseases in a school community.
- The practice dispensed weekly packs for people who needed support to manage their medicines.
- 'Just in case' medicine packs were supplied for use by district nurses caring for people at the end of life. Medicines and equipment were pre-packed and there was a standard process for prescribing the appropriate pain relief, so that the packs could be issued quickly when needed.

Access to the service

The practice was open between 8am and 6.30 Monday to Friday. Appointments were from 8.20am to 11.30am every morning and 3.30pm to 5.30pm daily. Extended hours appointments were offered from 6.30pm to 8pm Tuesday evenings, 7.30am to 8am Wednesday mornings and from 8:30am to 12:30pm on one Saturday a month. In addition

Good

Are services responsive to people's needs?

(for example, to feedback?)

to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The pharmacy/ dispensary opening times were from 8am to 7.30pm Monday to Friday, 9am to 1pm Saturday and 10am to 12 noon Sunday.

We were told the practice ran personal lists and GPs saw their own patients where possible to provide continuity of care. All patients with urgent problems were seen on the same day, however not necessarily by their own GP.

Results from the national GP patient survey published July 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 75% of patients were satisfied with the practice's opening hours compared to the CCG average of 81% and the national average of 78%.
- 90% of patients said they could get through easily to the practice by phone compared to the CCG average of 82% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice undertook a high number of home visits in order to meet the needs of elderly and housebound patients. The practice provided medical services to five care homes. The visiting GP triaged all visit requests to assess the urgency of the visit and to ascertain whether there may be more appropriate care pathways. The practice nursing team visited the practice housebound patients twice a year to review their chronic disease management, for example annual reviews for patients with diabetes They liaised closely with the patient's registered GP. We were told the practice team had built up strong relationships with patients and their families as a result of this service.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Listening and learning from concerns and complaints

The practice had an effective 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.
- We saw that information was available to help patients understand the complaints system. For example, there were leaflets, posters and

The practice had received 31 complaints from April 2015 to March 2016. The practice demonstrated a responsive attitude to recording and learning from complaints. We looked at 17 complaints received in the last 12 months and found these had been dealt with in a satisfactory and timely way and handled with an open and transparent approach.

Lessons were learnt from individual concerns and complaints and from analysis of trends and action taken as a result to improve the quality of care. However we noted there was scope to improve the recording of the complaint process and to ensure where appropriate complaints are reviewed as significant events. We discussed this with the practice who confirmed they would be reviewing their procedures. The practice also reviewed compliments and comments from patients; there was a suggestion box in the reception area. We noted that as a result of patient comments regarding the appointment system the practice had undertaken data audits, spoken with patients, representatives of the patient participation group and members of staff and as a result had revised the appointment system. The practice continued to monitor the impact of the appointment system.

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 clear vision to offer excellent medical care to patients in accordance with best practice and to offer the best employment conditions and support for staff with courtesy and respect in a welcoming environment and as efficiently as possible. This was detailed in the practice charter and the staff handbook. Staff we spoke with knew and understood the values. The practice ethos was for personal lists and continuity of care as much as possible with a strong emphasis on on-going training and education.

The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The practice reviewed their strategic plan every year to ensure they were meeting their objectives. The objectives included a provision of well embedded

support for staff and that the practice identified and acted on opportunities for improvement in a timely manner.

Considerations to changes in patient list size were also included, for example with the closure of practice lists across some local practices in Ipswich, the practice had seen a sharp increase in new patient registrations

The practice was part of a local group of GP practices, the Deben Health Group. A group brought together to work together on financial, educational and clinical matters and to share learning and development.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

· There was a clear staffing structure and that staff were aware of their own roles and responsibilities.

· Practice specific policies were implemented and were available to all staff.

· A comprehensive understanding of the performance of the practice was maintained

· A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

· There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

· The practice gave affected people reasonable support, truthful information and a verbal and written apology

· The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

· Staff told us the practice held regular team meetings.

· Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted that whole team meetings were held every six months.

· Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met every two months, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, PPG members attended annual flu clinics to meet with patients and canvas feedback. A PPG member attended the practice to promote practice patient surveys and friends and family surveys. In July 2016 in conjunction with the practice and the local CCG the PPG held a 'health awareness day' which provided health and social care information for patients.
- The practice produced quarterly staff and patient newsletters. These included practice news, health education and current NHS matters.
- The practice had gathered feedback from staff through meetings, one to ones and appraisals. Practice staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had been a training practice for over 40 years with a short gap following a partner retirement. The practice trained medical students and four partners were honorary senior lecturers at the University of East Anglia. In addition the practice provided training for medical students with one GP being a GP tutor. In addition to GP training the practice trained nurse practitioners via the graduate BSc qualification, with two of the practice nursing team obtaining their qualifications whilst working for and supported by the practice. Through the practice close workings with the pharmacy the practice was also assisting one of the pharmacy team to obtain their prescribing qualification.

The practice provided work experience for students from local schools interested in medicine; in addition the practice gave practise university interviews to support students preparing for university.

The practice worked with other local practices as part of the Deben Health Group where GPs and practice managers met on a regular basis to take collaborative working forward. The group benchmarked performance such as enhanced service contracts, staff salaries and skill mix. The strategy group consisted of GPs and practice managers who discussed larger scale working together and critical events. The group of practices had also held joint PPG meetings and shared staff across the practices. The group also shared relevant significant events to enhance practice learning across the group.