Bildeston Health Centre

Quality Report

The Health Centre,
High Street
Bildeston
Ipswich
Suffolk
IP7 7EX
Tel: 01449740254
Website: www.bildestonhealthcentre.co.uk

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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?	Outstanding
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 Bildeston Health Centre on 23 March 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- 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.
- 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.
- 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.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw areas of outstanding practice:

- The practice had developed their own template for care plans and health reviews and took active steps to ensure they discussed and recorded patients advance wishes for end of life where appropriate. The practice undertook regular audits of patients end of life

Summary of findings

outcomes and reported that in 2015 50% of those patients on end of life care pathways had died in their preferred place of death; an increase from 20% in 2010.

- The practice team ran a carers group which was set up in 2012. The practice held monthly meetings for carers at the practice where members of the team attended with carers and patients for afternoon tea and cake, support and advice and presentations by visiting speakers. For example the practice had facilitated presentations by Age UK, a holistic therapist who demonstrated head massage techniques and The Royal British Legion. These were well received by carers, the patients and their families with approximately 40 to 50 people in total with 15 - 20 attending the meetings each month. GPs told us this was a staff team effort, from the partners supporting and attending some meetings to the practice staff giving up their time to provide refreshments and lend a listening ear, and the practice domestic technicians setting up the rooms and clearing away at the end of the meetings.

The areas where the provider should make improvements are;

- Ensure patients with a learning disability receive an annual face to face review of their care plans.
- Ensure the practice is more proactive in recording all contacts with patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- 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 there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and 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 showed patient outcomes were at or above average for the locality and compared to the national average.
- 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 multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for almost all aspects of care. 94% described the overall experience of their GP surgery as fairly good or very good (CCG average 88%, national average 85%). 96% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 81%, national average 78%).

Summary of findings

- Feedback from patients about their care and treatment was consistently and strongly positive. 93% said the GP was good at listening to them compared to the CCG and national average of 89%. 96% said the last nurse they spoke to was good at treating them with care and concern (CCG and national average of 91%). 96% said they found the receptionists at the practice helpful (CCG average 89%, national average 87%). 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%. 100% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%).
- We observed a strong patient-centred culture. Members of staff volunteered to deliver medicines to patients who were unable to collect them from the practice.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. The practice had a carers' register, and members of the staff team were Carers' Champions. They ran a carers group which was set up by the practice team in 2012. The practice held monthly meetings for carers at the practice where members of the team attended with carers and patients for afternoon tea and cake, support and advice and presentations by visiting speakers. For example the practice had facilitated presentations by Age UK, The Royal British Legion, a solicitor who came to talk to the group about wills and the power of attorney and a holistic therapist who demonstrated head massage techniques. We were told these monthly meetings were well received by carers, the patients and their families and the practice saw approximately 40 to 50 people attend the meetings each month. GPs told us this was a team effort, from the partners supporting and attending some meetings. The practice staff gave up their time to provide refreshments and lend a listening ear, and the practice domestic technicians set up the rooms and cleared away at the end of the meetings.
- We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. The practice had developed their own template for care plans and health reviews and took active steps to ensure they discussed and recorded patients advance wishes for end of life where appropriate. The practice undertook regular audits of patients end of life outcomes and they were proud to report that 50% of those patients on end of life care pathways had died in their preferred place of death; we were told this was an increase from 20% when the audits were undertaken in 2010.

Summary of findings

- Views of external stakeholders were very positive and aligned with our findings.

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.
- 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.
- 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 this.
- 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 knowing about 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. The practice contacted housebound patients if they had not been seen by a GP.
- 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.
- The practice triaged all home visit requests to facilitate earlier visits where hospital admission may be an outcome.
- 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.

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.
- 81% of patients with diabetes listed on the practice register, had received a blood pressure reading that was 140/80 or less in the preceding 12 months. This was above the national average of 78%.
- 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.

Families, children and young people

Good

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

Summary of findings

- 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.
- 95% of patients with asthma listed on the practice register had received an asthma review in the preceding 12 months (April 2014 to March 2015). This was higher than the national average of 75%.
- 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 75%, which was below the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.
- 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.

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. The bowel cancer screening rate for the past 30 months was 66% of the target population, which was above the CCG average of 53% and the national average of 58%.The breast cancer screening rate for the past 36 months was 77% of the target population, which was comparable to the CCG average of 80% and above the national average 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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Of the 24 patients on the practice learning disability register, the practice computer system had recorded only six as having had received a face to face review of their care plans in the previous 12 months. The practice team were working to ensure all those with a learning disability received a face to face review of their health and that all such reviews were correctly coded on the computer system.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- 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.
- The practice had a carers' register, and members of the staff team were Carers' Champions. The practice team set up a carers group in 2012. There was a carers' board in the waiting room which was kept up-to-date by the practice team. The practice held monthly meetings for carers at the practice where members of the team attended with carers and patients for afternoon tea and cake, support and advice and presentations by visiting speakers. For example the practice had facilitated presentations by Age UK, The Royal British Legion and a range of complimentary therapies such as head massage.

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).

- 88% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months (April 2014 to March 2015), which is above the national average of 84%.
- 95% of patients experiencing poor mental health had their care reviewed in a face to face meeting in the last 12 months (April 2014 to March 2015), which is above the national average of 88%

Summary of findings

- The practice regularly worked with multi-disciplinary teams in the case management of people 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.

Summary of findings

What people who use the service say

The national GP patient survey results were published January 2016. The results showed the practice was performing above local and national averages. 238 survey forms were distributed and 131 were returned. This represented 55% completion rate.

- 99% found it easy to get through to this surgery by phone compared to a CCG average of 81% and a national average of 73%.
- 81% were able to get an appointment to see or speak to someone the last time they tried (CCG average 58%, national average 59%).
- 94% described the overall experience of their GP surgery as fairly good or very good (CCG average 88%, national average 85%).
- 96% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 81%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. All of the 21 patient comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two cards referred to the support given to patients and their families during the end of life and through bereavement. Cards also referred to members of staff across both clinical and non-clinical teams praising them for their kindness and compassion.

We spoke with15 patients. 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. T

Areas for improvement

Action the service SHOULD take to improve

- Ensure patients with a learning disability receive an annual face to face review of their care plans.
- Ensure the practice is more proactive in recording all contacts with patients.

Outstanding practice

- The practice had developed their own template for care plans and health reviews and took active steps to ensure they discussed and recorded patients advance wishes for end of life where appropriate. The practice undertook regular audits of patients end of life outcomes and reported that in 2015 50% of those patients on end of life care pathways had died in their preferred place of death; an increase from 20% in 2010.
- The practice team ran a carers group which was set up in 2012. The practice held monthly meetings for carers at the practice where members of the team attended with carers and patients for afternoon tea and cake, support and advice and presentations by visiting speakers. For example the practice had facilitated presentations by Age UK, a holistic therapist who demonstrated head massage techniques and The Royal British Legion. These were well received by carers, the patients and their families with approximately 40 to 50 people in total with 15 - 20 people attending the meetings each month. GPs told us this was a staff team effort, from the partners supporting and attending some meetings to the practice staff giving up their time to provide refreshments and lend a listening ear, and the practice domestic technicians setting up the rooms and clearing away at the end of the meetings.

Bildeston Health Centre

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, a practice nurse specialist adviser and a practice manager specialist adviser.

Background to Bildeston Health Centre

Bildeston Health Centre provide General Medical Services to approximately 6,900 patients. The practice area comprises of the village of Bildeston and the surrounding rural villages. The surgery is situated in a purpose built health centre, and has a dispensary within the practice dispensing to 87% of its patient list. The practice provides treatment and consultation rooms on the ground floor with ramp access and automatic doors. Parking is available. The practice demographic is weighted towards the older age groups, but with a high proportion in the early adult age group. 2% of its practice population are on the practice 'frail' register, with 2.6% identified as carers.

The practice has a team of three full time GPs and a full time advanced nurse practitioner. Three GPs are partners which meant they hold managerial and financial responsibility for the practice. In addition to this there is a team of practice nurses, which includes one nurse prescriber, two practice nurses and a healthcare assistant who run a variety of appointments for long term conditions, minor illness and family health.

There is a practice manager who shares the role with the dispensary manager. In addition there are six dispensers and a team of non-clinical administrative, secretarial and reception staff who share a range of roles, some of whom are employed on flexible working arrangements.

The practice is open between 8.20am and 6pm Monday to Friday. The practice runs an open surgery each morning with GPs from 8.30am to 10.30am; appointments are from 2pm to 5.50pm. Open surgeries are also available with the advanced nurse practitioner from 9.30am to 10.30am with appointments from 2pm to 5.50pm. Appointments with nurses are from 9am to 12.30pm and from 2pm to 5.40pm daily. The phlebotomist also runs an open surgery from 9am to 11am daily. The dispensary is open from 8.30am to 1pm and from 2pm to 6pm and from 9am to 12pm Saturdays. Extended surgery hours are offered each Saturday from 9am to 12am for pre-booked appointments. In addition to pre-bookable appointments that can be booked up to three months in advance, urgent appointments are also available for people that needed them. The practice did not run a duty GP system and all GPs and the advanced nurse practitioner were full time. We were told this ensured patients were able to see or speak to their clinician of choice and the practice rate for patients who did not attend for their appointments were very low in comparison to other practices as only afternoon appointments were available and extra patients were seen as required each morning.

Open surgeries provide on the day access. Patients can see the GP of their choice, take a number and wait. We were told choice is based on a variety of factors: some patients prefer continuity; others choose length of wait, or level of expertise for their condition. For those patients who prefer appointments the practice offers appointments in the

afternoons and on Saturday mornings. The practice also see acute extras at these times. We were told acute are shared out according to preference rather than running an "on call" system.

The practice does not provide GP services to patients outside of normal working hours such as nights and weekends. During these times GP services are provided via the 111 service.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 23 March 2016. During our visit we:

- Spoke with a range of staff including; GPs, the advanced nurse practitioner, practice nurses, healthcare assistants, dispensers, the practice manager and reception/ administration/ secretarial 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.

- 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 practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, the practice had identified a communication error with other services regarding the process for setting up syringe drivers (a device for giving medication) for patients with palliative care needs. To address this, the practice set up a multidisciplinary team meeting including all of the involved agencies, and held an educational session in palliative care. Other examples included an immunisation error. We saw that apologies were made, research about likely harm was undertaken and all clinicians were notified. The practice also reviewed positive events. For example and child with meningococcal sepsis was rapidly treated by the practice and transferred to hospital for a successful outcome. Lessons learned were disseminated throughout the teams and where required changes were put in place as a result of the reflection.

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 that reflected relevant legislation and local requirements and 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 was a lead 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 relevant to their role. GPs were trained to the appropriate level to manage safeguarding for children.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (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. The practice nurse 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.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. GPs liaised with and attended the monthly CCG prescribing meetings. The practice reported they worked in close collaboration with the CCG medicines management team and were consistently under their prescribing budget. GPs ran data searches to pick up high risk drug combinations, results or other markers so that the practice could act on them and intervene. The practice had appropriate written procedures in place for the production of prescriptions that were regularly reviewed and accurately reflected current practice.
- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. We saw processes in place for

managing national alerts about medicines, such as safety issues. Records showed that the alerts were distributed to relevant staff and appropriate action taken. There was a clear system for managing the repeat prescribing of medicines and a written risk assessment about how this was to be managed safely. Patients were able to phone in for repeat prescriptions, as well as order on line, in person or by post. Changes in patients' medicines, for example when they had been discharged from hospital, were checked by the GP who made any necessary amendments to their medicines records. This helped ensure patients' medicines and repeat prescriptions were appropriate and correct. We checked treatment rooms, medicine refrigerators and GPs' bags and found medicines were safely stored with access restricted to authorised staff. Suitable procedures were in place for ensuring medicines that required cold storage were kept at the required temperatures.

- Stocks of controlled drugs (medicines that have potential for misuse) were managed, stored and recorded properly following standard written procedures that reflected national guidelines. Processes were in place to check medicines were within their expiry date and suitable for use. Out of date and unwanted medicines were disposed of in line with waste regulations. Blank prescription forms and paper were handled according to national guidelines and were kept securely. Vaccines were administered by nurses using Patient Group Directions (PGDs) that had been produced in line with national guidance. PGDs were up to date and there were clear processes in place to ensure the staff who were named in the PGDs were competent to administer vaccines. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice.
- The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained and dispensed to 87% of its practice population. Dispensing staff had all completed appropriate training and had their competency annually reviewed. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. The practice had an established and well received service for delivering prescriptions to patients if it was difficult for them to collect from the surgery. Systems were in place to ensure the safe delivery of those medicines via volunteer members of staff. Prescription pads and blank prescription forms for use in printers were safely stored and handled in accordance with national guidance.
- We reviewed three 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.
- 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.

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 that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

- 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 in date.
- 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 peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, 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 98% of the total number of points available, with 9% exception reporting this was 4% above the CCG average and .2% below the national average. 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. The practice had identified their dementia referral rates as an area where they were an outlier for QOF, the practice had recognised the deficiency and over the last few months had moved to address this by improved read coding of contact with patients.

Data from 2014/2015 showed:

- Performance for diabetes related indicators was 89%, compared to the CCG and national average of 90%.
- Performance across all other indicators was above or in line with CCG and national averages with the practice achieving 100%. Where patients had been excepted from the indicator, the practice had done this for a justified reason.

Evidence of quality improvement included audits of exacerbations of chronic obstructive pulmonary disease during the winter months, providing patients with prescriptions of rescue antibiotics to prevent exacerbation of chest infections. The practice had undertaken three cycles of this audit, and despite the success identified from the first year using rescue antibiotics, this was not repeated in the second year. Initially the practice believed this to be due to a potential failure of the flu jab that year; however the third cycle of the audit proved equally unsuccessful. The practice believed that a positive outcome of this audit was that by providing rescue antibiotics to patients they were empowering them to prevent exacerbation of their condition during the winter months.

Another clinical audit looked at consent and post-operative complications for minor surgery undertaken at the practice, and the practice noted that no post-operative infections or failures for consent had been identified. Other audits looked at the prescribing procedures for high risk medications, the fitting of contraceptive devices and palliative care patients preferred place of death. These demonstrated improved recording of data and improved adherence to local prescribing guidelines. One outcome initiated a significant event where reported reviews of care understood by the practice to have been undertaken in secondary care prior to a repeat prescription being provided, were found to be inaccurate. We saw that as a result of this the practice had put systems in place to ensure these tests and checks were undertaken and reviewed by a GP before a repeat prescriptions was provided.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice also reviewed information from local hospitals, out of hours services and outpatients departments to identify patients who attended regularly, and might need to have their own personalised care plans.

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. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- 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 vaccinations and taking samples for the cervical screening programme had

received specific training which had included an assessment of competence. Staff who administered vaccinations 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 during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. 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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services 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. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. For example, a GP and the dispensary team during medication deliveries identified a carer for a vulnerable patient whose health was deteriorating. Safeguarding concerns were identified and discussed at MDT meetings. The care agencies, GPs, social workers and safeguarding agencies all liaised and as a result of regular visits, meetings and communication across all the services, systems were put in place to support a successful outcome for the patient and the carer.

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.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- 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.
- The process for seeking consent was monitored through records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. For example patients who might benefit from smoking cessation advice or weight management were provided with support from the practice clinicians and signposted to local support groups.

The practice's uptake for the cervical screening programme was 75%, which below the national average of 82%. 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. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The bowel cancer screening rate for the past 30 months was 66% of the target population, which was above the CCG average of 53% and the national average of 58%.The breast cancer screening rate for the past 36 months was 77% of the target population, which was comparable to the CCG average of 80% and above the national average of 72%.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were above CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% and five year olds from 95% to 100%. We were told that one member of the reception team was very active in this area and provided encouragement and support to parents for these immunisations, signposting parents to the practice nursing team for clear guidance and advice.

Flu vaccination rates for the over 65s were 1290 of the total patient population and at risk groups 606 of the total patient population.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

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 21 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two cards referred to the support given to patients and their families during the end of life and through bereavement. Cards also referred to members of staff across clinical and non- clinical teams praising them for their kindness and compassion.

We spoke with 15 patients. 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 in January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 93% said the GP was good at listening to them compared to the CCG and national average of 89%.
- 95% said the GP gave them enough time (CCG average 88%, national average 87%).
- 100% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%).
- 89% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- 96% said the last nurse they spoke to was good at treating them with care and concern (CCG and national average of 91%).
- 96% said they found the receptionists at the practice helpful (CCG average 89%, national average 87%).

These findings were reflected in our observations during the inspection and our conversations with patients and staff during the inspection.

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 on the comment cards we received was also positive and aligned with these views.

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

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 87% said the last GP they saw was good at involving them in decisions about their care (CCG and national average 82%).
- 89% said the last nurse they saw was good at involving them in decisions about their care (CCG average 87%, national average 85%).

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 178 patients, 2.6% of the practice list as carers. Written information was available to direct carers to the various avenues of support available to them. The practice had a carers' register, and

Are services caring?

members of the staff team were Carers' Champions. They ran a carers group which was set up by the practice team in 2012. There was a carers' board in the waiting room which was kept up-to-date by the practice team. The practice held monthly meetings for carers at the practice where members of the team attended with carers and patients for afternoon tea and cake, support and advice and presentations by visiting speakers. For example the practice had facilitated presentations by Age UK, The Royal British Legion, a solicitor who came to talk to the group about wills and the power of attorney, a holistic therapist who demonstrated head massage techniques, the Dementia Friends association and the Suffolk Family Carers whose tour bus attended in the practice car park. Following patient and carer requests the group had scheduled a second visit from Suffolk Family Carers for 2016 in addition to yoga and complementary therapy demonstrations, art sessions and a demonstration from a company who prepared and delivered ready meals to support people in their homes. We were told these monthly meetings were well received by carers, the patients and their families and the practice saw approximately 40 - 50 people in total with 15 - 20 people attending the meetings each month. GPs told us this was a team effort, from the partners supporting and attending some meetings. The practice staff gave up their time to provide refreshments and lend a listening ear, and the practice domestic technicians set up the rooms and cleared away at the end of the meetings.

Members of staff volunteered to deliver medicines to patients who were unable to collect them from the practice. As detailed previously in the report staff would often raise concerns with GPs and other health care providers where they identified cause for concern or deterioration in a patient's well-being.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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 a support service. CQC comment cards and patients we spoke with specifically praised the whole staff team for their kindness and support during end of life care for their family members. The practice website and reception area also provided signposting on support services available.

There were three nursing homes in the practice area and the practice took primary responsibility for one. GPs conducted regular ward rounds and medication reviews, which were audited by the practice. We were told that by doing this the practice had established a good rapport with the home and reduced unnecessary admissions, with improved end of life pathways to minimise distress for vulnerable patients.

The practice had developed their own template for care plans and health reviews and took active steps to ensure they discussed and recorded patients advance wishes for end of life where appropriate. The practice undertook regular audits of patients end of life outcomes and they were proud to report that 50% of those patients on end of life care pathways had died in their preferred place of death; we were told this was an increase from 20% when the audits were undertaken in 2010. We saw that nursing home patients also had a bespoke template to develop their care plan. We saw the practice scored very well in the local care home enhanced service audits for regular care reviews, medication reviews and falls assessments.

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 a 'Commuter's Clinic' on a Saturday morning from 9am to 12pmfor 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 would benefit from these.
- The practice provided sit and wait surgeries each morning from Monday to Friday. Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice had a self-service blood pressure machine. Results were reported by the patient to the receptionists, and if necessary an appointment was made.
- Services for children included school leaver's immunisations and meningitis C vaccinations for university students.
- The practice worked closely with community midwives, health visitors and mental health link workers, and promoted provision of these services from the surgery premises where possible. For example local midwives and the mental health link worker provided weekly clinics.
- Nurses provided spirometry, chronic obstructive pulmonary disease and asthma reviews and worked closely with the GPs to highlight any concerning results. In addition to this, the practice had a process in place where they would contact any patient following an admission to hospital for an asthma exacerbation or if the patient had contact with the out of hours service as a result of an asthma exacerbation.
- The practice offered in-house diagnostics to support patients with long-term conditions, such as blood pressure machines, electrocardiogram tests, spirometry checks, blood taking, district nursing, family planning and midwifery, health screening, health visitor, minor injuries and minor surgery.
- The practice offered a range of on-line services, which included; appointment bookings, prescription requests, Summary Care Records and on-line access to clinical records.
- The practice took part in discussions of hospital out-patient referral rates & prescribing data with other local practices within the CCG.
- The practice identified and visited the isolated, frail and housebound regularly. Chronic disease management was provided for vulnerable patients at home and the practice were active in developing care plans and admission avoidance strategies for frail and vulnerable patients.
- The practice liaised with the mental health link workers and other professionals to aid the management of those with mental health needs and those with chronic illnesses. In addition the practice worked with a local drug addiction support group and shared the care of ex drug abusers to monitor their medicines and general health.

Of the 24 patients on the practice learning disability register, the practice computer system had recorded only six as having had received a face to face review of their care plans in the previous 12 months. The practice were unclear as to why only six reviews were recorded as completed and they were investigating the recording of these on the computer system. Learning disability health checks were all undertaken by a GP. The practice had access to a range of easy read health information including health leaflets, support organisations and healthy food and exercises. Of the 39 patients on the practice mental health register, 18 had received a face to face review of their care plans in the previous 12 months.

Of the 46 patients on the practice dementia register, 35 had received a face to face review in the previous 12 months. The practice GPs told us that an area identified in which the practice needs to improve was the dementia referral rate. The practice recognised the deficiency and over the last few months had put plans in action to address this. For

Good

Are services responsive to people's needs?

(for example, to feedback?)

example one GP had undertaken extra training, staff were undertaking 'Dementia Friends' training and the practice computer system had been set up with at risk alerts to identify vulnerable patients.

Access to the service

The practice was open between 8.20am and 6pm Monday to Friday. Telephones were available from 8am to 6.30pm. The practice ran an open surgery each morning with GPs from 8.30am to 10.30am; appointments were from 2pm to 5.50pm. Open surgeries were also available with the advanced nurse practitioner from 9.30am to 10.30am with appointments from 2pm to 5.50pm. Appointments with nurses were from 9am to 12.30pm and from 2pm to 5.40pm daily. The phlebotomist also ran an open surgery from 9am to 11am daily. The dispensary was open from 8.30am to 1pm and from 2pm to 6pm and from 9am to 12pm Saturdays. Extended surgery hours were offered every Saturday from 9am to 12am for pre-booked appointments. In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for people that needed them.

The practice did not run a duty GP system and all GPs and the advanced nurse practitioner were full time. We were told this ensured patients were able to see or speak to their clinician of choice and the practice rate for patients who did not attend for their appointments were very low in comparison to other practices as only afternoon appointments were available and extra patients were seen as required each morning. The practice frequently surveyed patients on the open access appointment system and following the October 2015 survey 96% of patients who responded (699 responses) were happy with the practice open access and we were told would prefer to sit and wait in open access rather than wait a week to see someone.

Results from the national GP patient survey published in January 2016 showed that patient's satisfaction with how they could access care and treatment was significantly above local and national averages.

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 99% patients said they could get through easily to the surgery by phone (CCG average 81%, national average 73%).
- 81% patients said they always or almost always see or speak to the GP they prefer (CCG average 58%, national average 59%).

These results were reflected in the conversations we had with patients who were very happy with access to the service. We were told on the day of the inspection that they were able to get appointments when they needed them.

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 on the practice's website and in their information leaflet. Information about how to make a complaint was also displayed in the reception area. Reception staff showed a good understanding of the complaints' procedure. The practice manager was the designated responsible person who handled all complaints in the practice.

Patients we spoke with had not had any cause for complaint. We looked at complaints received in the last 12 months and found that they had all been responded to in a timely way. If a complaint was found to be on-going, the practice manager would continue to monitor the complaint until it was resolved.

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 deliver high quality care and promote good outcomes for patients.

- The practice aims and objectives were detailed in the practice statement of purpose. The practice aimed to provide patients with access to personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. To achieve this, the practice aimed to develop and maintain a happy, sound, family centred practice which was responsive to patients' needs and expectations and which reflected the latest advances in primary care. The practice ethos was to provide a courteous and caring healthcare service to the community.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

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.
- GPs provided peer support to each other, nursing and non-clinical staff through daily morning and lunch meetings to review care and treatment.

Leadership and culture

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

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 knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- They 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 in doing so and felt supported if they did.
- 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.

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 was very active and well attendeduntil two years ago when we were told constitutional roles and discussions were debated. As a result the practice now ran a virtual PPG. We saw that previous surveys resulted in action plans, the most significant being following the retirement from the practice of one GP. The practice aimed to run with three GPs but responded to the concerns raised

Are services well-led?

Good

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

regarding a lack of clinicians by employing a nurse practitioner. Other improvements included improved seating in the waiting room. The PPG were very active within the community, using flu clinics and various surgeries as well as village noticeboards, periodicals and other village meetings to distribute the questionnaire. The PPG received 699 responses to the latest survey as a result of PPG volunteers encouraging feedback. The practice also worked closely with a Friends of the surgery group and the carers group.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. We were told there were five main staff teams including nursing, reception, dispensing, managerial and secretarial and housekeeping. Each department had a GP partner lead and each department met regularly with the lead GP to discuss issues. However we saw that there was a culture of all staff meeting together daily in the common room for morning break and at lunch time. We were told this aided communication and did much to build team ethic and bonding. Non-clinical staff took leadership in various areas of the practice; leads were selected according to their areas of interest or expertise. For example health and safety, infection control or data protection. Staff turnover was low with some members of staff in place for 10 and 20 years. The practice provided protected training sessions for staff and GPs.

  Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a strong 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 regularly attended and participated with various healthcare organisations, currently the CCG and the local GP federation to help shape the provision of health services. The practice was a training practice and participated in the training of foundation year two student doctors.

The nurse practitioner was in the process of exploring nurse training and development of nurse practitioner training within the community. One GP had become a GP with a special interest in dementia and had been meeting twice monthly with the community mental team to increase diagnosis and improve management of dementia. In addition to this, the practice was becoming a dementia friendly practice. The practice had identified that some recordings of meetings and coding of visits required improvement. We were told that the practice team often called on patients out of surgery hours and often these friendly visits were not recorded, the practice had put systems in place to ensure all contacts with patients were recorded on the computer system to ensure continuity of care.