Thomas Yager & Partners

Quality Report

Botesdale Health Centre, Botesdale Health Centre,
Back Hills, Botesdale, Diss,
Norfolk.
IP22 1DW
Tel: 01379 898295
Website:www.botesdalehealthcentre.nhs.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?	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 visited Botesdale Health Centre Surgery on the 4 December 2014 and carried out a comprehensive inspection.

We found that the practice was good overall across all the areas we inspected.

Our key findings were as follows:

- The practice had a good understanding of the needs of the practice population and services were offered to meet these.
- Patients were satisfied with the service and felt they were treated with dignity, care and respect and involved in their care.
- There were systems in place to provide a safe, effective, caring and well run service. Practice staff were kind and caring and treated patients with dignity and respect.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made.
- The clinical staff at the practice provided effective consultations, care and treatment in line with recommended guidance.
- Services provided met the needs of all population groups.
- The practice had strong visible leadership and staff were involved in the vision of providing high quality care and treatment.

We saw areas of outstanding practice including:

The practice provides X-ray and Ultrasound equipment on site for the use of patients and those registered at neighbouring practices. This is overseen by a team of radiologists from West Suffolk Hospital.

The practice worked with the West Suffolk Hospital to provide outreach clinics at the practice. These included monthly Urology clinics, monthly Rheumatology clinic

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and fortnightly Orthopaedic clinics. There were weekly audiology clinics at the practice and monthly Women's Health clinics which were provided by a specialist physiotherapy service from the West Suffolk Physiotherapy team. These clinics were pre-booked directly with the hospital. This gave patients greater flexibility to choose where they would prefer to attend rather than travelling to local hospitals for these services.

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

The provider should:

- Ensure staff who are used for chaperoning patients receive chaperoning training to ensure they understand and can fulfil their role.
- Ensure the security of vaccines and unused prescription forms is in line with national guidance.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Clinical Excellence (NICE), acted upon updates and referred to the guidance routinely. The practice adopted the Gold Standards Framework for the treatment of people nearing the end of their lives and requiring palliative care. People's needs were assessed and care was planned and delivered in line with current legislation. The performance of the practice across key health areas was regularly monitored to ensure it achieved targets. Health promotion advice was readily available and patients signposted to external organisations and internal services to receive support. Staff were supported in the workplace, received annual appraisals to measure their competence and were trained appropriately. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams to ensure patients received the best care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly. Patients we spoke with and those who had taken part in surveys said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information was available at the practice that helped patients understand their condition and the services that were available to them both externally and within the Botesdale Health Centre. Staff treated patients with kindness and compassion and treated information about them confidentially. Patients with caring responsibilities were supported.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They were aware of their practice population and tailored their services accordingly. Patients were generally satisfied with the appointment system and the availability of the GPs and the nurse. Patients had a choice of GP if they wanted one. Telephone consultations and home visits were available when necessary. The premises were suitable for patients who were disabled or with limited mobility. There were X-ray and Ultrasound scan services available on site for patients. In addition, there were consultant appointments available on site for patient in areas such as audiology, urology and orthopaedics. There was an effective complaints system in place that was fit for purpose; we saw that complaints received had been dealt with in a timely and responsive manner.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for the delivery of high quality care and staff were working towards 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 team meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events. An ethos of learning and improvement was present amongst all staff.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group who might have a sudden deterioration in health. When needed, longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Facilities such as X-ray and ultrasound were available and appointments with specialists, for example audiologists and physiotherapists were available on site at the practice.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Antenatal care was referred in a timely way to external healthcare professionals. Parents we spoke with were

Summary of findings

positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of 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 at the practice which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Carers of those living in vulnerable circumstances were identified and offered support including signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. A lead for safeguarding monitored those patients known to be at risk of abuse. All staff had been trained in safeguarding and were aware of the different types of abuse that could occur.

People experiencing poor mental health (including people with dementia)

Good

The practice was aware of the number of patients they had registered who were suffering from dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP.

Summary of findings

Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations such as the mental health charity MIND and the community psychiatric nurse for provision of counselling and support.	

Summary of findings

What people who use the service say

We spoke with nine patients during our inspection. The practice had provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 26 comment cards, all the cards indicated that patients were more than satisfied with the support, care and treatment they had received from the practice. Comments cards also included positive comments about the services available at the health centre, appointment availability, cleanliness of the practice, the skills of staff, the way staff listened to their needs and being pleased with the on-going care arranged by practice staff. These findings were also reflected during our conversations with patients.

The feedback from patients was very positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice. The patients we spoke with told us they were happy with the service and they felt they got good treatment. Patients we spoke with told us the GPs and nurses always gave them plenty of time during their consultation. They told us that staff explained things and clinicians gave them sufficient time and information to be able to make decisions with regard to their treatment and care.

Patients told us that the GPs, nurses and receptionists were very supportive and they thought the practice was well run. We were told the GPs and nurses were supportive to the patients. Patients were able to describe to us how there had been effective communication between the GPs at the practice and other services. Patients knew how to complain, but told us they mostly had no complaints. Those patients who told us they had raised a complaint with the practice, told us they were happy with the way the practice had dealt with their concern and felt they had been listened to.

Patients told us they could mostly get an appointment when it was convenient for them and with the GP of their choice. Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity and the GPs and nursing team were very approachable and supportive.

Patients confirmed that they were happy with the supply of repeat prescriptions. Patients told us they would recommend the practice and were very happy with the practice facilities.

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

Areas for improvement

Action the service SHOULD take to improve

- The practice should ensure staff who are used for chaperoning patients receive chaperoning training to ensure they understand and can perform their role effectively.
- The practice should ensure the security of vaccines and unused prescription forms is in line with national guidance.

Outstanding practice

The practice provides X-ray and Ultrasound equipment on site for the use of patients and those registered at neighbouring practices. This is overseen by a team of radiologists from West Suffolk Hospital.

The practice worked with the West Suffolk Hospital to provide outreach clinics at the practice. These included monthly Urology clinics, monthly Rheumatology clinic and fortnightly Orthopaedic clinics. There were weekly audiology clinics at the practice and monthly Women's

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Health clinics which were provided by a specialist physiotherapy service from the West Suffolk Physiotherapy team. These clinics were pre-booked directly with the hospital. This gave patients greater flexibility to choose where they would prefer to attend rather than travelling to local hospitals for these services.

Thomas Yager & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Thomas Yager & Partners

Botesdale Health Centre provides general medical services Monday to Friday from 8am to 6.30pm and Saturday 7.50am to 12pm for pre-booked appointments only. The practice provides primary medical services to approximately 8,782 patients and is situated in central Botesdale near Diss, Norfolk. The building provides good access with accessible toilets and disabled car parking facilities.

The practice has a team of eight GPs meeting patients' needs. Five GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there were three practice nurses, nine dispensers, three pharmacists, the practice manager, office manager, two medical secretaries and a team of reception and administration staff. Botesdale is a training practice and GP registrars provide clinics throughout the year. The practice provides a pharmacy on site which is linked to the practice dispensary.

The practice provides X-ray and Ultrasound equipment on site for the use of patients and those registered at neighbouring practices. This is overseen by a team of radiologists from West Suffolk Hospital.

Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, support workers, health visitors and midwives. There are also a wide range of consultants led clinics from West Suffolk Hospital providing outreach services at the health centre.

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

Outside of practice opening hours a service is provided by another health care provider (Care UK), by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to six weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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

How we carried out this inspection

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

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

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

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

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 4 November 2014. During our inspection we spoke with a range of staff including GP partners, practice nurses, health care assistants, the pharmacist, dispensers, reception and administrative staff and the practice manager. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members and reviewed personal care or treatment records of patients. We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service.

We looked at records and documents in relation to staff training and recruitment. We conducted a tour of the premises and looked at records in relation to the safe maintenance of premises, facilities and equipment.

Good

Are services safe?

Our findings

Safe Track Record

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

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. Learning from safeguarding reviews was communicated internally at the quarterly significant event and weekly practice meetings. In addition any learning from safeguarding reviews was shared externally at the weekly multi-disciplinary team (MDT) Vulnerable and End of Life patients meetings. Staff told us that at the these meetings, the care and treatment of individual patients was discussed and outcomes were reviewed to establish if the practice could have delivered an improved standard of care. We saw the practice had learnt when things had gone wrong and put systems in place to improve safety and standards. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

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

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system Emis Web, which collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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

A chaperone policy was in place. Chaperone training had been undertaken by all nursing staff, including health care assistants. Staff told us that nursing staff were mostly used when chaperoning patients. However, we were told there were occasions when reception staff had been asked to chaperone. We were told these staff had not received chaperoning training. The provider may wish to ensure all staff who are required to chaperone patients receive training to ensure they are more informed about their role and the implications for protecting both the patient and the GP.

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

Medicines Management

The practice had a pharmacy attached which provided dispensing and medicines advice to patients from the trained pharmacists. We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary was tidy and operated calmly with adequate staffing levels.

Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. However we found that one of the fridges used to store vaccines was not securely locked and

was in a room which was also unlocked and unoccupied. This room was accessible to patients and the public and so constituted a risk. We also noted the arrangements for the secure storage for blank prescription forms did not follow national guidance. We discussed this with the GPs and practice manager who agreed to put improvements in place for the storage and security of medicines and blank prescriptions.

Dispensing staff had recorded a small number of dispensing errors since the start of 2014. We saw evidence that these incidents had been investigated but there were no documented action plans to minimise the same thing happening in the future. However, we were assured that if an error arose, it would be recorded and appropriate actions taken.

We found there was a comprehensive range of standard operating procedures for staff to follow but some of these were beyond the date identified for review.

Dispensing staff working at the practice had received training to undertake dispensing tasks. The practice manager told to us that the competence of staff to dispense medicines had been assessed, and we saw documentary evidence to support this. Therefore, we were assured that patients were dispensed their medicines by staff who had their competence regularly checked.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. Staff we spoke with knew how to handle patients' specimens appropriately and we saw a member of the reception staff receiving a patient's specimen correctly. Bags and gloves were available for staff to use when handling specimens.

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

There were infection control policies in place. There was also a policy for needle stick injury. Staff understood the importance of ensuring that the policies were followed. There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. The practice manager told us they did a daily visual audit of the practice. In addition the practice had undertaken regular cleaning audits. Areas highlighted for attention and the actions taken were recorded. The practice used contracted cleaning staff to oversee daily cleaning at the practice and held regular meetings with the cleaners to review the results of the cleaning audits and update the cleaning schedules.

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

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

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure monitors.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed

Good

Are services safe?

when recruiting clinical and non-clinical staff. We checked the records of two recently recruited staff. The records showed that staff were interviewed, and criminal records checks were carried out. Staff were provided with contracts of employment.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Contracts for newly appointed staff referred to this arrangement.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring Safety & Responding to Risk

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. The practice had plans in place to make sure they could respond to emergencies and major incidents. Plans were reviewed on a regular basis. Staffing establishments including staffing levels and skill mix were set and reviewed to keep patients safe and meet their needs. The right staffing levels and skill-mix were sustained at all hours the service was open to support safe, effective and compassionate care and appropriate levels of staff well-being.

We saw that staff were able to identify and respond to changing risks to patients including medical emergencies and this included responding to busy periods.

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

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

Staff told us they felt happy they could raise their concerns with the practice manager and were comfortable that these would be listened to and acted on. We saw that staff were supported in their role. Staff described what they would do in urgent and emergency situations.

Emergency medicines and equipment were available to use in the event of an emergency, for example a defibrillator. A defibrillator is an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present. There was a system in place to ensure emergency medicines were in date and stored correctly.

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

Staff confirmed if they had daily concerns they would speak with the GP's, the practice manager or the nurses for support and advice. The GPs discussed risks at patient level daily with the other clinician's in the practice.

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

Arrangements to deal with emergencies and major incidents

We saw records which demonstrated that both clinical and non-clinical staff had received training in Basic Life Support within an appropriate time frame. . All staff we asked knew the location of the Automated External Defibrillator, oxygen, pulse oximeter and nebuliser and records we saw confirmed these were checked regularly. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Good

Are services safe?

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included unplanned sickness, access to the building, power failure and adverse weather conditions. The document also contained relevant contact details for staff to refer to.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurses we spoke with were familiar with current best practice guidance, and carried out their assessments and consultations in line with guidance from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We found that clinical staff had a system in place to receive relevant updates about new guidelines and that these were then put into practice to improve outcomes for patients. The GPs told us they led in specialist clinical areas such as mental health and cancer. The nurses supported this work, but led on chronic obstructive pulmonary disorder, smoking cessation, hypertension and diabetes management. Members of the clinical and administrative team took a lead in different areas of care in line with the Quality and Outcomes Framework indicators. The Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care.

GPs attended training sessions and undertook e-learning modules that provided them with clinical updates so that their learning was continuous. Clinical staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

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

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

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were seen on need and that age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. We looked at several clinical audits on the day of our inspection. An analysis of the findings had taken place and where areas for improvements were identified these had been documented and actioned. Some clinical audits were linked to national patient safety and medicines alerts where the number of patients affected by them was reviewed and changes in medicines made, to improve the outcomes for them.

The practice used the Quality Outcomes Framework (QOF) to monitor their performance against national targets and screening programmes to monitor outcomes for patients. We found that the practice was achieving the required targets across the areas required of them including child immunisations, hypertension, diabetes and medication reviews and cervical screening. Their performance was the subject of monthly monitoring to ensure that patients were receiving the best outcomes.

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

The practice had implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. The practice

Good

Are services effective?

(for example, treatment is effective)

had a palliative care register and together with other healthcare professionals, the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes.

Staff meetings were used to discuss and monitor performance to ensure standards were maintained. Minutes of the meetings recorded regular discussion around practice performance and all staff were involved in the discussion.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as asthma and hypertension and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs and pharmacy lead had reviewed the use of a medicine to ensure that it was still appropriate for patients. Justifications for continuing to prescribe or not were recorded. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

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

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation, (every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). The practice recruited a number of administration and reception staff from the West Suffolk College apprentice scheme.

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Heads of each department within the practice were responsible for their team's appraisals. For example, nurse appraisals were undertaken by the senior nurse practitioner. Personnel files we examined confirmed these included reviews of performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as diabetes management and child safeguarding. As the practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was very positive.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, asthma and diabetes monitoring and administration of childhood and travel vaccines. We saw that the practice nurses had been provided with appropriate and relevant training to fulfil their roles.

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

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

Working with colleagues and other services

We found the practice worked well with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, the practice demonstrated they had developed effective working relationships with a local residential home which provided support for patients with

Good

Are services effective?

(for example, treatment is effective)

learning disabilities. Records we examined showed that these patients had received regular health checks. A representative of the home described the excellent support provided to the staff and patients by the GPs.

We also saw how the practice spoke and worked collaboratively with other hospitals and consultants to the benefit of its patients. The practice provided a designated room within the building for district nurses, consultants such as Urologists, Rheumatologists and Orthopaedics. There were also Audiology and Improving Access to Psychological Therapies (IAPT) services available for patients at the practice. Patients from other practices in the area were offered access to the practice X-ray and ultrasound clinics.

Blood results, X-ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

There were regular meetings, involving other different professionals, to discuss specific patients' needs. For example patients with end of life care needs, and children at risk. These meetings were attended by district nurses, social workers and palliative care nurses. The practice provided a designated room for the midwifery group attached to the practice. These specialist nurses looked after the practice ante-natal patients and undertook visits to mothers and babies following delivery. The midwives were able to access the practice computer system and liaise directly, either via the computer system or as a one to one meeting, with the GPs and nursing team. One midwife told us how very beneficial this had proved for continuity of patient care and support.

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

Electronic systems were also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Electronic systems were also in place for making some referrals through the Choose and Book system.

The practice had systems in place to provide staff with the information they needed. An electronic patient record EMIS Web was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's security and ease of use. The practice used information received to ensure patient care was being planned effectively. For example, the practice received hospital data on admissions and A&E attendances daily. This information was disseminated to the patient's named GP via email by an administrator within the practice.

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

Consent to care and treatment.

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

The practice had access to a telephone translation service although we were told they had not had need to use it. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care

plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

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

The practice told us that it has not been necessary to use restraint within the last 3 years. Staff were nevertheless aware of the distinction between lawful and unlawful restraint.

Health Promotion & Prevention

New patients who registered at the practice were offered a consultation for a new patient registration health check with a nurse to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors (e.g. smoking, alcohol intake, blood pressure, height, weight, BMI). Patients over 16 years of age were asked to complete a patient health questionnaire, including a request for information around smoking and alcohol intake. Advice was offered around access to smoking cessation clinics and safe alcohol limits. The GP was informed of all health concerns detected and these were followed up in a timely manner. Patients with long term health conditions or who were prescribed repeat medications were seen by a GP to review their repeat medications. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic health advice such as maintaining a healthy body weight and smoking cessation advice to smokers. The practice identified the smoking status of all their patients and this was also asked of new patients registering with them. They were encouraged to see the practice nurse who had received training to support patients wishing to give up smoking. Dieticians held monthly clinics at the practice to support patients in maintaining a healthy body weight.

Staff showed us and told us about the new patient's registration pack which included a consent form for patient care text messages, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record. Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

The practice offered NHS Health Checks to all its patients aged 40-75 and these checks were undertaken by the practice nurse. The performance of the practice in this area was the subject of regular monitoring and data reflected that targets were being achieved.

The practice identified patients requiring additional support. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. These patients attended appointments with other healthcare professionals for their annual review of their condition and on-going treatment was followed up by the practice when the relevant information had been received. Care plans in place were regularly reviewed. Weekly counselling clinics were provided at the practice by Suffolk Wellbeing Services.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice was pro-active in identifying patients, through posters in the surgery, the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available. There was a clear policy for following up non-attenders.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about support services, such as smoking

Good

Are services effective?

(for example, treatment is effective)

cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

The practice proactively identified patients, including carers who may need on-going support. The practice offered signposting for patients; their relatives and carers to organisations such as Help the Aged. A member of Suffolk Family Carers attended the practice every fortnight to provide support and advice for patients and their carers. A member of the patient participation group attended the practice during the weekly baby clinics to provide support and advice for new parents. One parent told us the practice and the PPG member also enabled a social network for new parents and provided refreshments for mothers waiting to see the clinicians.

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

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey with a 47% completion rate and a survey of 67 patients undertaken by the practice's Patient Participation Group. The evidence from all these sources showed patients were highly satisfied with how they were treated and that this was with kindness, dignity and respect. For example, data from the national patient survey showed 100% of the respondents had confidence and trust in the last nurse they saw, 99% responded that the nurses were good at treating them with care and concern, giving them enough time and explaining their treatments. 98% of the respondents reported they had confidence and trust in the last GP they saw, 97% responded that the last GP they saw was good at giving them enough time, 94% reported that the GPs were good at involving them in decisions and 96% of respondents reported the GP was good at listening to them. 96% reported the receptionists to be helpful and 92% reported they found it easy to get through to the surgery by phone.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 26 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were professional, caring, kind and experienced. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said they were treated with compassion and their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. There were private changing rooms and gowns provided for people who were attending for X-ray or Ultrasound scan appointments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Patients we spoke with were aware of the availability of chaperones if they required them and were able to give us examples of their experiences with a chaperone present during their consultation. They told us they were satisfied with the way their consultations had been carried out.

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

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they were satisfied with the explanations of their care and treatment by the GPs and nurses. We were told they felt the GPs and the nurses explained things in a way they understood and took the time to provide the explanations.

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

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

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.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

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

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

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. We found that the practice understood the needs of the patients using the service and the services were tailored to patients' needs to ensure flexibility, choice and continuity of care.

Patients over 75 years of age had a named GP to ensure continuity of care for the elderly. Patients could request to see a GP of their choice and this was accommodated on most occasions. Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of ten minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us they did not feel rushed during their appointment, that the GPs listened and understood their concerns, explained things to them and gave them the time they needed.

The appointment system was effective for the various population groups that attended the practice. Patients told us that they rarely had to wait until the next day to obtain an appointment and they were very complimentary about accessing consultations with both GPs and nurses.

Patients were able to request repeat prescriptions by email or to attend the practice personally. Prescriptions would be ready within 48 hours, but patients we spoke with told us that they were often ready for collection earlier.

The practice had achieved and implemented the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patient and their families care and support needs.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. Audio loop was available for patients who were hard of hearing and staff were knowledgeable about the different needs of the patients who attended. All the treatment and consultation rooms were situated on the ground floor.

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

The appointment check-in facility in the practice was set up to reflect the most common languages in Botesdale. Staff had access to an interpretation and translation service. However they were knowledgeable about language issues and described how they would access an interpreter to the benefit of the patient. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. We saw evidence of staff supporting people who were unable to use the booking in screen or read the appointment information monitor in the reception area.

Patients who were homeless were able to use the practice's address to register as a temporary patient.

Equality and diversity training had been provided to staff.

Access to the service

Appointments were available daily from Monday to Friday in the morning and afternoons. Pre-bookable appointments were available on Saturday mornings. Patients could also register to book appointments online. The practice was closed Saturday afternoons and on Sundays and did not offer a late evening appointment.

The practice gave priority to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day wherever possible. We spoke with seven patients on the day who told us that they had been able to get appointments for themselves, their family members or their children when required.

Patients could select their GP of choice if they were available. Chaperones were readily available for patients to use on request.

The practice did not run separate clinics for people with long term conditions as they found that they could meet patient needs with an appointment system. There were health promotion clinics available, such as for smoking cessation. The practice provided diagnostic services such as digital X-rays and ultrasound scans. These were

Good

Are services responsive to people's needs?

(for example, to feedback?)

managed by staff from the West Suffolk Hospital, however the equipment had been provided at the practice by the GP partners and with the support of the Friends of Botesdale Health Centre (a charity established in 1982 consisting of patients of the practice who wished to provide support for the Health Centre for the benefit of patients, the practice and the local community), appointments for these services were also available for patients from neighbouring practices. The practice also worked with the West Suffolk Hospital to provide outreach clinics at the practice. These included monthly Urology clinics, monthly Rheumatology clinic and fortnightly Orthopaedic clinics. There were weekly audiology clinics at the practice and monthly Women's Health clinics which were provided by a specialist physiotherapy service from the West Suffolk Physiotherapy team. These clinics were pre-booked directly with the hospital. This gave patients greater flexibility to choose where they would prefer to attend rather than travelling to local hospitals for these services.

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

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system.

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

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. We saw that complaints recorded in the last 12 months had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice.

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 the very highest quality medical care to its patients in a friendly courteous and professional manner. They had an up to date statement of purpose that clearly described their objectives, vision and strategy. Staff spoken with were aware of the direction of the practice and were working towards it.

Staff job descriptions and appraisals supported the direction in which the practice wished to head and they were clearly linked to the vision and objectives. Staff felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available for staff to read. We viewed several of these policies and found that they had been reviewed and read by staff. Policies included information governance, infection control, chaperones and safeguarding.

There was a clear leadership structure within the partners, the practice manager and team leaders such as nursing, reception and office managers. Designated leads included infection control, chronic disease management such as diabetes, pharmacy/dispensing, safeguarding, complaint handling, and health and safety. Staff we spoke with were aware of the various leads and knew who to discuss issues with if the need arose.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. This is an annual incentive programme designed to reward good practice. The QOF data for this practice showed it was performing above local and in line with national standards. We saw that QOF data was reviewed each month to ensure that health targets were being achieved. This was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice undertook a range of audits that monitored the quality of the services they provided. These included prescribing medicines, risk assessments and infection control audits. One such audit covered monitoring the use of a weight loss prescribed medicine, the read coding of patients prescribed this medicine and the subsequent monitoring of the effectiveness of the medicine to improve outcomes for patients.

The practice had robust arrangements for identifying, recording and managing health and safety risks. These were clearly identified and reviewed on a regular basis to ensure that patients and staff were safe.

Team meetings were used to discuss issues and improve practises.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for complaints. The members of staff we spoke with all clear about their own roles and responsibilities.

We saw from the minutes we looked at that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. Where staff were absent for any reason they were provided with minutes of the meetings to enable them to remain up to date. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was a low turnover of staff.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place that included example disciplinary procedures, induction policy and job descriptions which were in place to support staff. A staff handbook was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice carried out annual surveys to seek feedback from patients. The results of each survey had been analysed to identify areas for improvement and these had been actioned wherever possible. We noted that from the last GP patient survey in 2014, 97% of respondents stated

Are services well-led?

Good

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

they would recommend the practice to someone new to the area, 94% of respondents described their experience of making an appointment as good and 95% of respondents reported the last nurse they saw or spoke with was good at giving them enough time. were satisfied with the services provided. One area for improvement was the time kept waiting to see the GP. According to the survey 37% of respondents reported waiting more than 15 minutes once arriving at the practice to see a GP. This was also highlighted in the Patient Participation Group (or Friends of Botesdale Health Centre) PPG patient survey as an issue and acknowledged by the practice. The practice had a very active PPG. This is a group of patients registered with the practice who have an interest in the service provided by the practice. Action had been taken to help improve in this area including systems to inform patients of any delays or expected waiting times with the use of patient call in screens, check in screens and the reception team and discussions with the GPs so they were aware of the issue. The PPG survey had noted a 10% increase in patient waiting time satisfaction since the previous year's patient participation survey.

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

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

Management lead through learning & improvement

We viewed records that effective appraisal processes were in place that had been maintained over a number of years. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. Staff files reflected that training had been identified and provided to staff to enable them to meet the needs of the patients.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and away days to ensure the practice improved outcomes for patients Audits, the results of a patient survey and the analysis of significant events were used to improve the quality of services. Where audits had taken place these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.