Dr Bouch and Partners

Quality Report

Bridge Road Surgery,
1a Bridge Road,
Oulton Broad,
Lowestoft,
Suffolk.
NR32 3LJ
Tel: 01502 565936
Website: https://bridgeroadsurgery.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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection report published 3 September 2015 - Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Dr Bouch and Partners on 6 December 2017 as part of our regulatory functions.

At this inspection we found:

- The practice had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the practice learned from them and improved their processes.
- Effective monitoring processes were in place, which included for example, health and safety, recruitment, training and appraisals. The practice had three non clinical staff who had not attended the recent basic life support refresher training and two staff who had been off sick when their appraisal was scheduled. However the practice were aware of this and had scheduled these to be completed.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines. Support and monitoring was in place for the clinical pharmacist and nursing staff, and the monitoring of the work undertaken by the nurse practitioners was formalised and effective.
- Staff treated people with compassion, kindness, dignity and respect and involved them in decisions about their care and treatment. All staff had received equality and diversity training. The practice patient information leaflet was available in large print and audio format.

Summary of findings

- Patients found the appointment system easy to use and reported that access to appointments was positive; this was supported by a review of the appointment system and data from the National GP Patient Survey. The practice were aware of patient feedback in relation to the length of waits once patients had arrived for their appointment. This had been discussed with all the GPs and informal and formal feedback mechanisms were agreed.
- The practice had responded to the needs of patients and suggestions from staff. We saw a number of examples of this including health checks for patients with a learning disability being undertaken in their own home, raising the height of the patient toilet and changing the days practice meetings took place.
- Information on the complaints process was available for patients at the practice and on the practice's website. There was an effective process for responding to, investigating and learning from complaints.
- Staff had the skills, knowledge and experience to carry out their roles and there was a strong focus on continuous learning and improvement at all levels of the organisation. Staff we spoke with felt supported by the practice.

The areas where the provider should make improvements are:

- Ensure the non-clinical staff members complete the planned basic life support refresher training.
- Monitor the exception rates for the quality and outcomes framework data, with the aim to reduce this over time.

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

Summary of findings

Areas for improvement

Action the service SHOULD take to improve
The areas where the provider should make improvements are:

- Ensure the non-clinical staff members complete the planned basic life support refresher training.
- Monitor the exception rates for the quality and outcomes framework data, with the aim to reduce this over time.

Dr Bouch and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP specialist adviser and a CQC inspector.

Background to Dr Bouch and Partners

- The name of the registered provider is Dr Bouch and Partners. The practice address is Bridge Road Surgery, 1a Bridge Road, Oulton Broad, Lowestoft, Suffolk, NR32 3LJ.
- The practice is registered to provide diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.
- The practice has a general medical services (GMS) contract with the local Clinical Commissioning Group (CCG).
- There are approximately 12,550 patients registered at the practice.
- The practice website is https://bridgeroadsurgery.nhs.uk
- The practice is a training practice for qualified doctors who are training to become GPs.
- The practice has a below average number of patients between the ages of 0 to 44, an average number of patients between the ages of 45 to 59 and an above average number of patients over the age of 60 than the national average. Male and female life expectancy in this area is in line with the England average at 80 years for men and 84 years for women. Income deprivation affecting children is 18%, which is below the CCG average of 25% and in line with the England average of 20%. Income deprivation affecting older people is 15% which is in line with the CCG average of 17% and the England average of 16%.
- The practice had registered approximately 3,000 new patients in October 2015, following the closure of a nearby GP practice.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice conducted safety risk assessments. There was a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. The practice had a lead and deputy for safeguarding. Laminated safeguarding children and adults information was clearly displayed in clinical rooms and throughout the practice and outlined who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Safeguarding was a standard agenda item at clinical and partners business meetings. The practice had prompts set up on the computer system to alert staff of the need to consider if a child was at risk.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. These were recorded on the practice's computer system. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. One clinician and three non-clinical staff had not completed the basic life support refresher training, which had been held the week before the inspection. The practice were aware of this and confirmed that the clinical member of staff had completed this the day after the inspection. The training for the three non-clinical staff was scheduled to be completed at the practice, the week after the inspection. Staff who acted as chaperones were trained for the role and had received a DBS check. Chaperone notices were displayed in the clinical rooms and in the reception and waiting area.
- There was an effective system to manage infection prevention and control. A comprehensive infection control audit had been completed in November 2017 and three actions had been identified. One of these had been completed and work was being undertaken to meet the other two actions. Staff had received training in infection control and guidance and notices were available for staff.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Guidance was available to reception staff and staff we spoke with were aware of this. Staff knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, the practice had completed a home visit request audit in June and September 2017 and had reduced the number of home visit requests from an average of six to two per day. They had written pictorial information leaflets on appropriate and inappropriate requests for home visits to help to inform patients. As a result of this work, the practice now prioritised the review of requests for urgent home visits, which improved patient safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care

and treatment was made available to relevant staff in an accessible way. Templates were in place for acute consultations to ensure that all appropriate areas were considered and checked.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The practice's computer system generated a reminder for the GP if a patient failed to attend a booked appointment, in order for them to review and take action as appropriate.
- Trained administration staff reviewed some GP correspondence, in order to increase GPs clinical time. A GP audited this work to ensure that it was undertaken safely.
- We reviewed three referral letters and clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. The practice kept prescription stationery securely. The prescription paper was recorded when it was received; however, there was no process to track it thoughout the practice. The practice immediately added this information to the tracking process already in place.
- We reviewed the records of patients who were prescribed medicines which required additional monitoring, for example methotrexate and lithium. All the records we looked at showed that patients were appropriately monitored before medicines were re-prescribed.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. Antibiotic prescribing was comparable to the clinical commissioning group and national averages.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- A clinical pharmacist reviewed patients on multiple and complex medicines and reviewed the medicines of all patients who were discharged from hospital. They sought the advice of a GP if necessary. Their work was supervised by a GP and also their employer, who was an external organisation.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues. These included for example, fire, health and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). Regular checks were completed and documented in relation to these areas and the environment.
- The practice monitored and reviewed activity. This helped to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. Significant events were marked as complete when identified actions had been completed and were given a risk rating on the likelihood of reoccurrence.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, an urgent referral had been delayed; these were now actioned by clinicians immediately after seeing the patient. There was a system for recording and acting on safety alerts. The practice learned from external safety events and patient safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice, and all of the population groups, as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients received a full assessment of their needs. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had a self-testing blood pressure machine, which patients were invited to use. Results were passed to reception staff who had guidance on action to take, depending on the results presented.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Older people:

- Nationally reported data showed that outcomes for patients with conditions commonly found in older people, including rheumatoid arthritis, dementia and heart failure were in line with the local and national averages. However the exception reporting for one of the sub indicators for rheumatoid arthritis was 34%, compared to the CCG average of 13% and the national average of 8%. The practice advised that this was due to a high number of patients who were reviewed by the hospital team and declined a review at the practice.
- GPs and nursing staff provided weekly home visits to patients who lived in five care homes covered by the practice.
- Clinicians visited housebound patients and patients in care homes to undertake influenza vaccination, chronic disease management reviews and health checks.
- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- GPs reviewed older patients discharged from hospital and ensured that their care plans were updated to reflect any additional or changed needs.

People with long-term conditions:

- Nationally reported data showed that outcomes for patients with long term conditions, including diabetes, asthma, chronic obstructive pulmonary disease (COPD), hypertension and atrial fibrillation were in line with the local and national averages. However the exception reporting data for two of the asthma sub indicators were above the CCG and England average. For one of the asthma indicators, it was 29%, compared to the CCG average of 15% and the national average of 8%. For the other it was 25%, compared with the CCG average of 10% and the national average of 5%. The practice advised that this was due to patients declining invitations to attend for a review. The practice were aware of the data and had been raising patients' expectations of how they could be supported to manage their own health.
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and nurse practitioner worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of people with long term conditions had received specific training.
- 99% of patients with long term conditions, who were recorded as current smokers had received discussion and advice about smoking cessation. This was in line with the CCG average of 96% and the national average of 97%.

Families, children and young people:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- There were positive examples of joint working with midwives, health visitors and social workers. Midwives held a weekly clinic at the practice. Mother and six week baby checks were undertaken with the patient's usual GP. Processes were in place to follow up on patients that did not attend.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target

Good

Are services effective?

(for example, treatment is effective)

percentage of 90% or above. For example, rates for the vaccines given to under two year olds ranged from 96% to 99%. Appropriate follow up of children who did not attend for their immunisations were in place and a protocol was in place to support this.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 78%, which was slightly below the 80% coverage target for the national screening programme. The CCG average was 83% and the national average was 81%. The practice advised that their uptake rate had reduced significantly when approximately 3,000 patients from a nearby surgery registered at the practice and they had been working to increase the uptake since this time.
- The practice invited eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks which included new patient checks and NHS checks for patients aged 40 to 74. The practice had offered 404 health checks between April 2016 and March 2017 and 300 had been completed. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Appointments for patients with long term conditions were available throughout the week to enable patients more convenience in booking a suitable appointment time.

People whose circumstances make them vulnerable:

- Annual health assessments for people with a learning disability were undertaken by the practice nurse and the GP, at two separate, but consecutive appointments. The practice currently had 53 patients on the learning disabilities register, of which 33 had received a health review in the previous 12 months. The practice also undertook home visits to complete health assessments for patients who may feel more comfortable in their own environment.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and mental health needs.

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

- 81% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the CCG average of 82% and the national average of 84%.
- 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was in line with the CCG average of 89% and the national average of 90%. The exception reporting was 48% which was above the CCG average of 20% and the national average of 13%. The practice advised that this was due to patients declining invitations to attend for a review.
- 93% of patients who experienced poor mental health had received discussion and advice about alcohol consumption, which was in line with the CCG average of 88% and the national average of 91%. The exception reporting was 43% which was above the CCG average of 18% and the national average of 10%. The practice advised that this was due to patients declining invitations to attend for a review. The practice were aware of this data and had been raising patients' expectations of how they could be supported to manage their own health.
- The practice liaised with local mental health services, which included a psychogeriatric service to obtain advice and support for patients experiencing poor mental health, including those with dementia.
- The practice had a mental health link worker, who offered appointments on a weekly basis for patients. They reviewed the needs of patients with mental health needs with GPs as appropriate.
- Staff at the practice had received dementia awareness training.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. In the previous year the practice had undertaken 13 clinical audits of which two were two cycle audits. One clinical audit reviewed the use of low dose aspirin in older patients for cardiovascular

Good

Are services effective?

(for example, treatment is effective)

prevention, and the need for this to be taken alongside gastroprotection medicine. The first audit in June 2017 identified 46% of patients who were prescribed aspirin without gastroprevention medicine. The repeated cycle in November 217, showed that this had reduced to 13%.

The most recent published Quality Outcome Framework (QOF) results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 81% and the national average of 95%. The overall exception reporting rate was 14% compared to the CCG average of 13% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) Some of the clinical indicators had a high level of exception reporting. The practice was aware of this and explained this was due to a number of issues. They had registered approximately 3,000 new patients in October 2015, following the closure of a nearby GP practice and were working to raise patients' expectations of how they could be supported to manage their own health. Some patients declined invitations to attend for review, despite appropriate recall systems being in place and some indicators had very low patient numbers, which skewed the data. We reviewed this information and data and deemed it to be appropriate.

- The practice scored above the CCG in 24 of the 25 clinical and public health indicators, and significantly below for one indicator. They scored above the national average in 22 of the clinical and public health indicators and below in three. The practice scored 0% for cardiovascular disease – primary prevention and the exception rate was 100%. The practice advised that this was due to both very low patient numbers and their refusal to commence a statin medicine. We reviewed this data and deemed it to be appropriate.
- The practice performed well compared to local benchmarking standards. It was third out of 40 practices for low levels of unplanned admissions to hospital and low levels of outpatient referral, second for low levels of one day or less admission to hospital, fourth for total avoidable admissions and ninth for low use of accident and emergency.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, the practice had supported nurses and the clinical pharmacist to undertake their prescribing training and one practice nurse to become a nurse practitioner.
- The practice provided staff with ongoing support. This included one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

Good

Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included for example, patients who wanted to give up smoking, those who wanted to lose weight and increase their activity levels and carers.
- The practice had increased the number of diabetes clinics from two to four a week from June 2017, to offer education to patients identified as being at risk of diabetes; with the aim of reducing the risk of these patients developing diabetes. Patients were invited for an annual review, which included a lifestyle assessment, education and advice.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and the NHS Flu campaign.
- 82% of females between the ages of 50 and 70 had been screened for breast cancer in the preceding 36 months, compared to the CCG average of 72% and national average of 73%.
- 65% of eligible patients had been screened for bowel cancer in the preceding 30 months, compared to the CCG average of 60% and national average of 58%.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. The practice monitored the process for seeking consent appropriately. The practice had undertaken a clinical audit in January 2017 which showed that appropriate consent had been obtained in the 10 patient records reviewed. The practice planned to repeat this audit annually and increase the sample number of patients reviewed.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, and social needs. A confidentiality notice aimed at patients under the age of 16 was displayed in the practice, which gave clear information to patients.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Seven of the eight patient Care Quality Commission comment cards we received were positive about the service experienced, although one highlighted the length of wait once they had arrived for their appointment. The most recently published NHS Friends and Family Test data from February 2017, showed from the 5 responses, 100% of patients would recommend the practice. Data has been submitted since February 2017, however the number of responses was less than five so these are not published to protect against the risk of patient identifiable data. Feedback was also positive from representatives from the five care homes where patients were registered at the practice.

Results from the July 2017 National GP patient survey showed patients felt they were treated with compassion, dignity and respect. 223 surveys were sent out and 107 were returned. This represented a 48% completion rate. This represented just under 1% of the practice population. Results were in line with local and national averages:

- 91% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 89% of patients who responded said the GP gave them enough time compared with the CCG average of 88% and the national average of 86%.
- 92% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 87% and the national average of 86%.
- 95% of patients who responded said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 96% of patients who responded said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 90% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 89% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 88% and the national average of 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard:

- Interpretation services were available for patients who do not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. The practice leaflet was available on the website and in the practice in a larger font. This was also available in audio format for patients who were registered blind or had poor eyesight.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers. Carer's information was displayed in the practice which included advice for young carers. The practice also asked patients to identify themselves as carers, or having a carer. This was

Good

Are services caring?

included in the new patient registration form. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 236 patients as carers (2% of the practice list).

- Suffolk family carers attended the practice every four to six months to offer advice and support to carers. Known carers were invited into the practice at these times.
- Staff told us that if families had experienced bereavement, their usual GP contacted them to offer them support and advice, in the way that their GP felt to be most appropriate.

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

- 92% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%.
- 96% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 92% and the national average of 90%.
- 94% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and improved services in response to those needs. For example the practice had extended opening hours on a Saturday from 8am until 11.30am, online services such as repeat prescription requests and advance booking of appointments.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when people found it hard to access services. For example, following a patient suggestion, the practice had raised the height of one of the patient toilets for patients that find lower toilets difficult to use.
- The practice had a hearing loop, a type of sound system used by patients who use hearing aids.
- Patients were able to refer themselves for physiotherapy advice or treatment at a locally based service.
- Practice clinicians had delivered education to staff who worked in care homes in relation to diabetes and the use of an epipen, which is an automatic injection device which contains medicine to treat serious allergies.

Older people:

- All patients had a named GP.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- Influenza vaccinations were also completed at home, for older people who were housebound.
- GPs and nursing staff provided weekly home visits to patients who lived in five care homes covered by the practice.
- The practice had organised a half day event hosted by Age UK, with a specific focus on identifying and supporting older patients who were lonely.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one double length appointment, and consultation times were flexible to meet each patient's specific needs.
- The nurse practitioner started patients on insulin therapy and offered a daily telephone support service to these patients.
- Long term condition reviews were completed at home, for patients who were housebound.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- 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.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Systems were in place to follow up on children under 16 who did not attend for their appointment.

Working age people (including those recently retired and students):

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, Saturday appointments were available from 8am to 11.30am with a GP and a nurse
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- 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.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and mental health needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice offered longer appointments, appointments earlier in the day, to minimise waiting times and home visits if necessary for patients with a learning disability.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Health checks for people with a learning disability were also undertaken in the patient's own home, if this made them more relaxed. We were told about a patient who now visited the practice as the nurse had built a positive rapport with them, which had reduced their anxiety.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia. Staff had received training in dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Timely access to the service

Generally, patients reported that they were able to access care and treatment from the practice within an acceptable timescale for their needs. One of the CQC patient comments card, advised of dissatisfaction with the length of wait once they had arrived for their appointment. Another comment advised that there was often a wait to get a non-urgent GP appointment. One patient we spoke with also advised this, although they explained that they choose to wait to see their GP of choice. We reviewed the patient appointment system and found that urgent and pre-bookable appointments were available in a timely way.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 National GP patient survey showed that patients' satisfaction with how they could access care and treatment was generally comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 81% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 81% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 77% and the national average of 71%.
- 93% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 88% and the national average of 84%.
- 86% of patients who responded said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 77% of patients who responded described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 54% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 64%.

The practice had reviewed the results from the survey and had prioritised three areas, which included length of wait to be seen. This had been discussed with all the GPs and informal and formal feedback mechanisms were agreed.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately. It improved the quality of care in response to complaints and concerns.

- Information about how to make a complaint or raise concerns was available on the practice's website and in the practice and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice had received 15 complaints since April 2017. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It

Good

Are services responsive to people's needs?

(for example, to feedback?)

acted as a result to improve the quality of care. For example, clinicians had undertaken training following a patient attending with a non-standard presentation of a deep vein thrombosis.

Are services well-led?

Good

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

Our findings

We rated the practice as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. For example, the practice had supported one nurse to become a nurse practitioner and a new registered manager had been identified, as the current registered manager was retiring. The practice had identified the risks with the imminent retirement of GPs and had used this as an opportunity to identify and implement alternative options.
- The practice worked with seven other local GP practices as a group called Lowestoft Primary Care Alliance. The group had recently obtained funding to have access to a shared computer system, which would be used, for example to share jointly written and agreed policies.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. It had a realistic strategy and supporting business plans to achieve priorities.
- The practice management team developed its vision, values and strategy at practice meetings and incorporated the views of patients, staff and external partners. This document was regularly reviewed when issues were identified.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The practice had examples where complaints were raised as significant events and outcomes of these were shared with staff and patients. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. Staff were able to speak openly and had confidence that any issues raised would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. The majority of staff had had an appraisal in the last year and these were scheduled for two staff who had been off sick when they were originally scheduled. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity and all staff had received training in this area. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Are services well-led?

Good

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

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- A number of staff had lead roles and all staff were clear on their roles and accountabilities.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. These were reviewed regularly.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks, which included risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. There was a process for responding to and managing patient safety alerts, incidents, complaints and compliments.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made; this was with input from clinicians to understand their impact on the quality of care. For example, improved patient education in relation to home visit requests had resulted in home visits reducing from approximately six to two per day from June 2017 to September 2017, with no impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any weaknesses.
- The practice used information technology systems to monitor and improve the quality of care. For example, all significant events, complaints and compliments were available on the practice's computer system and all staff were able to access these. All staff were informed by email when these were added to the system.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- Staff suggestions and the practice responses were logged and staff gave some examples of when their suggestions had resulted in changes. For example, meetings were no longer held on Mondays, due to the heavier workload on Mondays. These were now held on alternate Wednesdays and Thursdays, which enabled more part time clinicians to attend as they worked on these days.
- The practice kept a record of patient suggestions and identified repeated suggestions in order to make improvements to the service provided. For example, music in the waiting room is now turned off some of the time to accommodate the wishes of patients. They also collated compliments received and shared feedback with the staff involved.

Are services well-led?

Good

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

- There was an active patient participation group (PPG) who met every two months with the practice manager and a member of administration staff. There were 12 patients on the PPG and we spoke with one of them. They advised that the group was informative, they felt listened to and the practice made changes as a result of their feedback. For example, the need for continuity of GPs was identified by the PPG and also through the National GP Patient survey. Reception staff now booked patients into an appointment with their own GP, unless it was clinically urgent or their GP was not available.
- The practice had reviewed the National GP Patient survey results published in July 2017 and had identified priority areas; actions were in progress and had been taken to improve these areas.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The practice was a training practice for qualified doctors training to become GPs and supported the training of student nurses. They were in the process of becoming a teaching practice for medical students who were training to become doctors. The practice also employed a GP through the GP Fellowship Programme, which supported newly qualified GPs.
- The practice identified the need to increase the number of long acting reversible contraception devices that could be fitted by practice clinicians. Training was undertaken and the number of staff who could provide this service had increased; 41% of implants were fitted at the practice in 2015, which compared to 94% being fitted in 2017.
- The practice had two GP leads for research and a practice nurse employed for research for half a day per week and they actively recruited patient participants. For example in 2015 to 2016 the practice had recruited 61 patients for seven studies and at the time of the inspection, the practice had recruited116 recruits from six studies. One research study looked at the identification of familial high cholesterol through a heel prick blood test taken at the 13 week baby immunisation appointment. The practice identified one patient who was prescribed a medicine to reduce blood cholesterol as a result of being involved in this research study.
- The practice were planning care navigator training for reception staff in order that they would be able to signpost patients more effectively to alternative and appropriate services, where possible.