Christmas Maltings and Clements Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Christmas Maltings and Clements Surgery on 17 December 2014, as part of our new, comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be safe, effective, caring, responsive and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care.

Our key findings were as follows:

- All of the patients we spoke with told us they were involved in decisions about their care and treatment and many complimented the quality of the clinical care they received.
- Faced with a national shortage of GPs, the practice had adopted alternative ways to meet patients' needs. This included employing a nurse practitioner and an emergency care practitioner.
- The practice had implemented new initiatives in order to respond to patient demand and the effectiveness of new processes was continually monitored.
- We found the practice was clean and patients we spoke with told us they had no concerns about cleanliness or hygiene at the practice.

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

The provider should:

- The practice recruitment policy should include the arrangements for undertaking criminal records checks using the Disclosure and Barring service for clinical and non clinical staff.
- Ensure that staff acting as chaperones understand their responsibilities when undertaking that role.
- Ensure that blank prescription forms are kept securely, so they cannot be accessed by unauthorised people.
- Ensure that information is available informing patients that they can ask to speak to the receptionist in private, if necessary.

Summary of findings

- Ensure that the induction programme completed by new staff to the practice is documented.
- Consider whether there is scope to widen and further embed learning through improved record keeping around significant events.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned. Staff had received appraisals and personal development plans were in place for all staff. We saw evidence of multidisciplinary working.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. The practice had responded to the needs of patients using the most effective use of the resources they had. Patients reported that there could be a long wait for a routine appointment. There was a sit and wait service so that patients who needed to be seen on the day were seen by a clinician. The practice used to offer extended hours appointments but had temporarily stopped providing these to prioritise clinical cover on weekdays. We were told extended hours appointments were going to recommence in April 2015.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice had a virtual patient participation group (PPG) and sought feedback from staff and patients which had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits, and rapid access appointments for those with enhanced needs.

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 that included a referral system so that patients in this group could receive timely care and support if they experienced a sudden deterioration in their health. When needed, longer appointments and home visits were available. All these patients had structured annual reviews to check their health and medication needs were being met. For patients with the most complex needs clinical staff worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who may be at risk of abuse. For example, children and young people who had a high number of A&E attendances or those with non accidental injuries. The practice were achieving acceptable immunisation rates for all standard childhood immunisations. We saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Patients we spoke with also confirmed this. 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. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working age adults (including those recently retired and students). The needs of the working age population, those recently retired and students, had been identified. The practice was not currently offering extended hours appointments, due to prioritising clinical cover on weekdays, but these were due to recommence in April 2015. The practice was proactive in offering online services and telephone consultations, as well as a full range of health promotion and screening which reflects 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. Longer appointments were offered to patients with most need, for example for those with a learning disability. A translation service was available for patients with limited understanding of the English language and longer appointments were provided to ensure adequate time was given when a translator was used.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Dementia screening and memory clinics were provided at the practice. Patients with dementia were offered advance care planning.

The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had mental health needs who had not attended for their appointment and if there was concern.

Summary of findings

What people who use the service say

Before our inspection we received comments from patients who had given feedback to Healthwatch Suffolk. These comments were mainly received in July 2014, but they ranged from March 2014 to October 2014. The majority of the comments were negative and related to the closure of the walk in centre in Haverhill. The comments which related to the practice included the need for more GPs, difficulty in obtaining an appointment and appointments not being available in the evening and weekend. There were some positive comments about how the practice were doing the best they could and were trying different approaches, including a sit and wait service, to meet the patients' needs.

We spoke with representatives from three care homes where patients were registered with the practice. They spoke positively about the service received from the practice. We were told that there was continuity of care for patients who were usually seen by the same two or three GPs. One home received a weekly visit from a named GP for patients with any health concerns and medicine reviews were undertaken during a monthly visit.

We spoke with approximately 20 patients during our inspection. We received mixed comments about the appointment system. Many patients commented negatively on the length of wait to see a GP for a routine appointment and the waiting time to be seen in the sit and wait service. All of the patients we spoke with informed us they were involved in decisions about their care and treatment and the majority of patients told us they were treated with dignity and respect by staff at the practice. Patients said they found the practice was always clean and tidy.

Prior to visiting the practice we left Care Quality Commission comment cards for patients to complete, describing their experience of the practice. We reviewed 34 comment cards. Most of the comments on the cards were positive, particularly about the clinical care provided. Five comments cards gave negative views, three of which related to the length of wait for a routine appointment, one related to the waiting time to be seen at the sit and wait service and one related to feeling rushed during a sit and wait appointment.

Areas for improvement

Action the service SHOULD take to improve

- The practice recruitment policy should include the arrangements for undertaking criminal records checks using the Disclosure and Barring service for clinical and non clinical staff.
- Ensure that staff acting as chaperones understand their responsibilities when undertaking that role.
- Ensure that blank prescription forms are kept securely, so they cannot be accessed by unauthorised people.
- Ensure that information is available informing patients that they can ask to speak to the receptionist in private, if necessary.
- Ensure that the induction programme completed by new staff to the practice is documented.
- Consider whether there is scope to widen and further embed learning through improved record keeping around significant events.

Christmas Maltings and Clements Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and two GP specialist advisors. The team also included a practice nurse specialist advisor, two inspectors, a pharmacy inspector and an expert by experience.

Background to Christmas Maltings and Clements Surgery

Christmas Maltings and Clements Surgery, also known as Christmas Maltings and Clements Practice is located in Haverhill in Suffolk. The practice operates from The Christmas Maltings Surgery, Camps Road, Haverhill, Suffolk, CB9 8HF and Clements Surgery, Greenfields Way, Haverhill, Suffolk, CB9 8LU. There is also a branch surgery, Kedington Surgery, 36 School Road, Kedington, Suffolk, CB9 7NG. There is a dispensary at the Christmas Maltings Surgery.

The practice provides services for approximately 18,000 patients living in Haverhill and the surrounding villages. According to Public Health England information, the patient population has a slightly higher than average percentage of patients aged under 18 and slightly lower percentage of patients aged 85 or over, compared with practice average across England. Income deprivation affecting children and older people is significantly lower compared to the practice average across England.

The practice is a partnership of six GPs who hold financial and managerial responsibility for the practice. The practice employs six salaried GPs, seven registered nurses, including a nurse practitioner, an emergency care practitioner and three health care assistants. There is also a dispensary team, which includes a manager and senior dispenser. There is a practice manager and a team of non-clinical, administrative and reception staff who share a range of roles.

The practice is open between 8am and 6:30pm on weekdays. Pre-booked advance appointments could be made in person, by telephone or online. Patients who had an urgent need could telephone the practice and were advised of the sit and wait service at Clements Surgery. Patients could also turn up at Clements Surgery and if they needed to be seen on the day, the receptionist would ask them to sit and wait to see clinical staff. Early morning appointments for blood test appointments were also available.

Christmas Maltings and Clements Surgery does not provide an out-of-hours service to patients. Details of how to access emergency and non-emergency treatment and advice was available within the practice and on its website.

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.

Detailed findings

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.

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

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the service. We spoke with representatives from three care homes where patients were registered with the practice. We talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch Suffolk. The information they provided was used to inform the planning of the inspection.

We carried out an announced visit on 17 December 2014. We visited Christmas Maltings surgery and Clements Surgery. We did not visit the branch surgery at Kedington as part of our inspection.

During our visit we spoke with a range of staff including GP partners, salaried GPs, nurses, health care assistants, reception and administrative staff and the practice manager. We spoke with approximately 20 patients who used the service. We spoke with three members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We reviewed 34 CQC comments cards that we had left in each surgery, for patients to complete if they chose. We observed how staff interacted with patients and reviewed the care and treatment records of patients.

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We noted that positive significant events were also completed in order to raise awareness and share good practice. An example was given by one of the GPs in relation to the identification of non-accidental injury to a child.

We looked at complaints records, records of incidents and notes of management and practice meetings. These records showed that incidents, feedback and concerns were discussed and outcomes and any learning arising from the incidents were communicated to staff through practice meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists, administrators and nursing staff were aware of the system for raising incidents and felt encouraged to do so. We saw incident forms were available on a shared drive on the practice computer system. Once completed these were sent to the practice manager who showed us the system used to oversee how these were managed and monitored.

Records were kept of significant events that had occurred and these were made available to us. We reviewed a number of significant events and saw evidence of the action taken as well as the learning to improve practice. One significant event related to the need for the practice to have oxygen available on site. We noted that sufficient supplies of oxygen were available at each practice and these were checked regularly to ensure they were fit for purpose. We saw that some significant events highlighted good practice or were raised to emphasise the need for vigilance. For example one significant event was in relation to raising awareness of the recognition of non-accidental injury.

The practice held regular significant event meetings to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. We noted that it was difficult for all clinical staff to attend significant event meetings due to other commitments and could therefore miss useful information about lessons learned from the events. Records of the meeting could be improved to widen learning across practice staff.

National patient safety alerts were disseminated by email to practice staff as necessary. Staff had to respond to confirm that appropriate actions had been undertaken. Nursing staff, GPs and dispensary staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed in the clinical meetings to ensure all clinicians were aware of their relevance to patient care at the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. Staff confirmed to us that this was the case. Staff knew how to recognise signs of abuse in vulnerable adults and children. 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. Contact details were easily accessible. Staff provided appropriate examples of when they had raised safeguarding concerns. However, they told us they were not always informed of the outcome.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children who had the necessary training to enable them to fulfil this role. All staff we spoke with were aware of the lead GP and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and notices informing patients of this service were visible in the waiting rooms. Chaperoning was undertaken by clinical staff and non-clinical staff were asked if they wanted to act as a chaperone. Although we saw certificates that some staff had received chaperone training, the staff we spoke with

told us that they had not received training for this role. Staff were not clear of their responsibilities when acting as chaperones. For example, chaperones did not document in patients' records that they were present during a procedure.

Medicines management

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. We observed this process was working in practice.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

The practice had established a service for people to pick up their dispensed prescriptions at the Kedington Surgery and had systems in place to monitor how these medicines were collected. There were also arrangements in place to ensure that people collecting medicines from these locations were given all the relevant information they required.

There were systems in place to check that medicines were within their expiry date and suitable for use. Spot checks we completed demonstrated that medicines were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

There was a clear policy for ensuring medicines that required refrigeration were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described. Refrigerator temperatures were taken at least once every working day and these were documented. We noted that a record of the temperature of the room had not been documented. We spoke with the nursing staff about this who added the room temperature to the recording log, so this would now be documented.

We checked medicines stored in the medicine refrigerators were stored securely and were only accessible to authorised staff. However, we found medicines stored at Clements Surgery were not locked and could have been accessed by patients. We were informed by the practice manager the day after the inspection, that a lock had been purchased and was being fitted to the medicines cupboard the next day.

There was a process in place for tracking the serial numbers of blank prescription forms. However we found blank prescription forms which could have been accessed by patients. We raised this with the practice management team who said they would look into improving the security of these.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were daily and monthly cleaning schedules in place and cleaning records were kept. Daily spot checks of the cleanliness of the rooms were undertaken. Hand hygiene technique signage was displayed in staff and patient toilets and all clinical rooms. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a nurse and a GP 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. All staff received induction training about infection control specific to their role and thereafter annual updates. We saw evidence the lead had carried out audits every three months and that any improvements identified for action were completed on time, for example the replacement of hand washing posters. We saw that bi-monthly hand washing audits were undertaken.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example the use of personal protective equipment, dealing

with needle stick injuries and the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).

Staff we spoke with and our observation of the treatment areas showed that infection control measures were in place. This included the safe disposal of sharps and clinical waste, the use of disposable privacy curtains and regular checks of the water supply. We found that the water checks were not recorded and the practice agreed to start this.

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. This included weighing scales and blood pressure equipment.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However this did not contain any information on the need for completing criminal record checks using the Disclosure and Barring Service for clinical and non-clinical staff.

We looked at clinical staff files and these 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 manager confirmed that DBS checks had been undertaken for non-clinical staff who undertake chaperoning. We did not see these records as we were told that these were kept at the other practice site.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. For example, nine week baby and new mother checks were planned and staffing levels changed according to the number of patients identified that were due to be reviewed. We saw there was a rota system in place for 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.

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. We observed that the waiting time to be seen for patients who used the sit and wait service could be lengthy and some of the patients we spoke with expressed this view. The practice management team explained the challenges they had in meeting patients' needs in a timely way, due to the limited GP cover they could provide. They were working hard to recruit more GPs, but this remained an on-going issue. They told us that they had tried a number of systems to respond to patient demand and they continually monitored feedback following new initiatives to see if they were effective. The evidence demonstrated that the practice worked hard to ensure that patients' needs were met.

Monitoring safety and responding to risk

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

The practice manager met with the managing partner weekly and discussed any risks. These were then shared at the partners meeting. The practice manager did not keep a risk log and was not aware of any outstanding risks. They advised us that any risks were identified and actions taken to resolve the risk immediately.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All the staff we spoke with at the practice were aware of how to respond to a possible deterioration in a patient's condition. We saw records showing the majority of staff had received training in basic life support. One of the GPs at the practice provided this training and a date was planned for two staff to complete this. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to

Good

Are services safe?

restart a person's heart in an emergency). All staff who we asked knew the location of this equipment and records we saw confirmed these were checked regularly. In the notes of the practice's significant event meetings, we saw that a medical emergency concerning a patient had been discussed and appropriate learning had taken place.

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 a number of emergency medical conditions, for example, 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.

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 for example, power failure, adverse weather, unplanned sickness and access to the building. The document also contained an appendix of relevant contact details for staff to refer to. Two of the staff we spoke with gave an example of when the business continuity plan had been used and was effective.

The practice had a fire safety policy. Plans of the building with identified evacuation routes were available in each room. Notices were displayed where oxygen and other medical gases were stored. Locked red boxes marked 'fire information' were located inside the front entrance of the practice. Staff had been trained to manage fire evacuation procedures and were aware of the procedures to follow in the event of a fire. This had been extended to the practical use of a fire extinguisher where staff had the opportunity to practice using one in a controlled situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and effect on patients were discussed and any required actions were agreed. The staff we spoke with and evidence we reviewed confirmed these actions were focused on achieving the best health outcome for patients. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs each had specialist clinical knowledge in areas such as women's health, minor surgery, paediatrics, dermatology, teenage health, psychiatry, respiratory disease and dementia. The practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us that they supported all staff to continually review and discuss new best practice guidelines such as for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

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 referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Due to the difficulty the practice had in recruiting more GPs, they had prioritised the need to provide direct patient care. This had resulted in them not being able to easily demonstrate the high quality of care they provided, for example by using the Quality and Outcomes framework. However, we did see evidence of the high quality of care delivered to patients, from feedback from patients and by reviewing a sample of patient notes.

We asked to see the clinical audits completed by the practice. A clinical audit is an assessment of clinical practice against best practice for example, clinical guidance, to measure whether agreed standards are being achieved, and to make recommendations and take action where standards are not being met. The practice acknowledged that undertaking clinical audits had been difficult, due to the difficulties they had in recruiting GPs and the subsequent need to prioritise direct patient intervention. Improvements to the number of completed clinical audits were required if patient outcomes were to be maintained.

We reviewed one completed clinical audit cycle which related to the documentation of the assessment of fever in children under five years of age. We saw that improvements had been made to the documentation of the assessment undertaken and the inclusion of additional areas of assessment which were considered valid, for example, documenting parental perception of a fever.

Two GPs in the practice undertook minor surgical procedures, although this primarily involved joint injection procedures, in line with their registration under the Health and Social Care Act 2008 and National Institute for health and care excellence (NICE) guidance. They were appropriately trained and kept up to date with their knowledge.

The practice was participating in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for patients most at risk of unplanned admissions and regular review meetings were held to assess effectiveness. Patients who were at the end of their life were also reviewed regularly by a multi-disciplinary team. We found that the practice had been effective in reducing the number of admissions. There was also evidence that patients' needs had been anticipated proactively so that appropriate support was available when this was needed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that the majority of staff were up to date with attending mandatory courses such as annual basic life support and fire safety. A good skill mix was noted amongst the GPs. Due to the location of the practice being

Good

Are services effective?

(for example, treatment is effective)

approximately 18 miles from the nearest Accident and Emergency Department, the practice employed a nurse practitioner and an emergency care practitioner to effectively meet patients' needs.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. This included for example, the administration of childhood immunisations and cervical cytology. Nurses with extended roles, for example seeing patients with long-term conditions such as asthma, COPD and diabetes were also able to demonstrate they had appropriate training to fulfil these roles. The nurses had maintained their continuing professional development requirements in order to ensure their continued registration with their relevant clinical professional bodies.

All GPs were up to date with their yearly continuing professional development requirements and had either 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).

We reviewed the induction policy and induction plans for new staff. We looked at the records of staff induction and found they were not all fully completed. However the staff we spoke with confirmed that they had received an induction which supported them to undertake their role effectively.

All staff undertook annual appraisals which identified learning needs from which personal development plans were agreed. Staff appraisal schedules confirmed that this had taken place and staff we spoke with told us that they felt supported, skilled and valued. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. For example, one member of staff was supported to obtain an NVQ 3 in practice management and another an NVQ in business administration.

We saw evidence of staff receiving training to cover each other's roles. The deputy practice manager was learning aspects of the practice manager's role, so they could effectively cover this role as necessary.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs including complex needs. 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. These were allocated to the most appropriate GP working that day who was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

There was a robust process in place for the management of referrals made by the practice. The practice has a computer based system for all referrals to be dictated onto. This enables the secretaries to see all the outstanding referrals. At the time of our inspection, standard referrals were being made within 10 working days. Urgent referrals were processed the same day and two week wait referrals were actioned immediately. Patients could be referred to GPs within the practice, to benefit from their specialist knowledge.

The practice had identified those patients who were at risk of unplanned admission to hospital. They had worked with other members of the multi-disciplinary team to develop individual care plans. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients including access to same-day appointments and clinical consultations on the telephone.

The practice held multidisciplinary team meetings and palliative care meetings to discuss the needs of complex patients. This included for example, patients with palliative care needs or children at risk. These meetings were attended by district nurses, a community matron, social workers and palliative care nurses. We viewed the minutes of these meetings which had been clearly recorded and they reflected that individualised care was being provided. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice had systems in place to provide staff with the information they needed. The practice had recently transferred to a new computer system, called SystmOne. We were unable to determine how effective this system was

Good

Are services effective?

(for example, treatment is effective)

due to its recent implementation. However all the staff we spoke with and observed were able to operate the new system. The practice manager told us that this computer system was chosen as the other practices and the community services in Haverhill used this. They planned that future co-operation between practices and other services would be facilitated by the common clinical system.

We saw that information was shared appropriately between the other services involved in patient's care. Records we saw showed that palliative care meetings took place monthly with a range of professionals to ensure there was a joined up approach to care and treatment for the patient. There was effective information sharing for example with the out of hours provider and district nurses. We saw that information regarding patients who were at the end of life was shared with the out of hours provider. This ensured that care and support would be seamless if the patient needed a GP out of hours.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary. We were told that verbal consent was recorded in patient notes where appropriate. Patients that we spoke with and received comments from confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an in depth understanding of the legal requirements when treating children. The practice nurse confirmed that consent was always obtained from parents prior to immunisations being given. Staff also understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Guidance was available to staff in relation to The Mental Capacity Act (2005). This provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. The clinical staff we spoke with were aware of the requirements of the Mental Capacity Act (2005) and their responsibilities in relation to this. All staff were aware of patients who needed support from nominated carers and clinicians ensured that carers' views were listened to as appropriate.

Health promotion and prevention

All new patients were encouraged to make an appointment for a consultation with a nurse when they registered with the practice. This enabled the nurse to focus on particular areas of health concern when they saw them for their first appointment. The practice asked patients to complete a new registration form which included information about their lifestyle, social factors and medication. Following their review, patients were signposted to support within and outside of the practice in order to meet their needs. Patients with long term conditions were added to the chronic disease register and invited for review.

There was a range of health promotion leaflets available in the waiting area with information to promote good physical and mental health and lifestyle choices. We saw information about support and advice that was available for people with dementia, mental health and for those who were carers.There were also leaflets signposting patients to other local and national support and advice agencies. Information about health promotion was available on the practice website.

The practice held smoking cessation and weight loss clinics, to provide additional support to patients with specific health needs, They also undertook dementia screening and a memory clinic was held on an individual basis. We saw that patients with diabetes had received appropriate monitoring which was in line with the national level. Patients aged between 40-75 years old were invited for a well woman/well man health check. All of the nurses at the practice were trained to undertake cervical screening and received three yearly updates. The uptake of cervical screening was in line with the national level.

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. Through discussion with staff and from records viewed we saw that the practice performed well and had a high uptake for both childhood and adult immunisation and vaccinations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at data from the 2014 National GP Patient Survey. 92% of patients reported that the reception staff were helpful and 90% of patients thought they were treated with care and concern by the nursing staff. These results were above average when compared with other practices in the Clinical Commissioning Group (CCG) area. 62% of patients reported that they were satisfied with the level of privacy in reception and satisfaction rates for patients who thought they were treated with care and concern by their doctor, was 78%. These results were below average when compared with other practices in the Clinical Commissioning Group (CCG) area.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 34 completed cards and the majority were positive about the service experienced. Patients said they felt the staff were efficient, helpful and caring. Some of the staff were named, as providing a particularly positive service. The majority of patients expressed that staff treated them with dignity and respect. We also spoke with approximately 20 patients on the day of our inspection. All told us that their dignity and privacy was respected by staff at the practice.

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. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. In response to patient and staff suggestions, a system had been introduced to encourage only one patient at a time to approach the reception desk. This minimised patients overhearing potentially private conversations between patients and reception staff. Staff told us that if patients were discussing particularly sensitive information they would ask them if they wanted to use a private room. However we did not see any notices advising patients that this option was available to them.

Care planning and involvement in decisions about care and treatment

The 2014 National GP Patient Survey showed that 74% of patients felt the GP was good at giving them enough time, 86% felt that the GP was good at listening to them and 79% felt that the GP was good at explaining test results to them. 68% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were lower than the average for the local Clinical Commissioning Group (CCG) area. The corresponding figures for the nursing staff were rated higher than the CCG average. 89% of patients felt the nurse was good at giving them enough time, 91% felt that the nurse was good at listening to them, 89% felt that the nurse was good at explaining test results to them and 69% of patients felt that the nurse was good at involving them in decisions about their care.

Patients we spoke with, and received comments from told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by clinical staff. All of the patients, apart from one, felt they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

A recent GP survey undertaken by the practice had identified the need for patients to feel more informed about their health condition. The practice had recently moved to a new computer system where they were easily able to print off patient information leaflets in order to address this identified need.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, and practice website signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We were told that Suffolk Family Carers visited the practice once a week to talk with patients who were carers and to offer them support and advice.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care

Good

Are services caring?

professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families. We saw that relatives of patients who were at the end of life were often given the GPs personal mobile so that they could contact the GP responsible for the patients care if needed.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or signposting to a support service. We received a comment card from one patient who commended the practice on the bereavement support they received from the practice.

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, particularly given the GP recruitment difficulties. The needs of the practice population were understood and systems were in place to address identified needs. For example there was a significant need for urgent appointments, so the practice had recently introduced a sit and wait system for patients who needed to be seen urgently. The practice recognised that this was not suitable for all patients, so they continued to have telephone consultation when appropriate to do so. They had also employed a nurse practitioner and an emergency care practitioner to support further with meeting patients' needs appropriately.

Home visits were made to a local care home on a specific day each week, by a named GP. We spoke with a representative from a care home who confirmed that this happened. They also provided positive feedback regarding the service provided to patients by the practice. They told us that each month the GP reviewed all patients' medicines, which they found beneficial.

The practice worked collaboratively with other agencies and regularly shared information with other professionals to ensure good, timely communication of changes in care and treatment. This included holding regular palliative care and multi-disciplinary team meetings. We were told that there was good liaison with the mental health team. The mental health team were contacted in relation to patients with mental health needs who did not attend for an appointment and where there was concern.

Tackling inequity and promoting equality

We looked at the measures in place at the practice to accommodate patients' equality, diversity and information needs. The practice provided equality and diversity training via e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last twelve months. Staff at the practice provided support to patients who were unable to read and/or write to complete registration forms.

There was a booking in touch screen in the reception area with a variety of languages available for patients whose first language was not English. Where patients did not speak English as a first language, interpreting services were made available to support them to fully access the service. Where patients required longer appointments due to increased communication or language needs, these were made available.

The practice staff were aware of the areas of significant deprivation in the practice population they provided a service to. The clinical staff met regularly and worked closely with members of the multi disciplinary team to ensure the needs of patients living in poverty were identified and addressed.

Access to the service

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.

The information from CQC comment cards and patients we spoke with indicated that some patients were satisfied with the appointments system. The majority confirmed that they could see a doctor on the same day if they needed to. One patient told us their relative who worked, found it was difficult to get an appointment, especially since the Saturday morning service was no longer available. We spoke with the practice about this and they advised that they would be providing appointments over extended hours from April 2015, which would support improved access for patients who worked.

We reviewed 34 comments cards of which five contained comments where patients expressed dissatisfaction with either the time it takes to see a GP for a non-urgent appointment or the waiting time to be seen at the sit and wait service. We saw evidence that the practice had tried a number of ways to best meet patients' needs in response to feedback from patients.

Christmas Maltings Surgery had level access throughout for patients who used wheelchairs as well as wider doors and accessible toilets. Clements surgery was situated in a building with two floors. Consultation and treatment rooms were located on the ground and first floor. Stair and lift

Good

Are services responsive to people's needs?

(for example, to feedback?)

access was provided to the first and second floors. The practice made arrangements for patients with restricted mobility, or those who did not like using the lift, to be seen in one of the ground floor rooms. We saw that the waiting areas were 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. There was also a functioning hearing loop in reception

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice.

There was clear written information available to patients, which described the complaints process and how they could make complaints and raise concerns. These were kept on the reception desk and were available for patients to take without having to ask. This information included details of the timelines for investigating and responding to complaints and concerns. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman. This is a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

We looked at two complaints received in the last 12 months. We found that these had both been acknowledged, investigated and responded to in line with the practice complaints procedure. The responses had occurred in a timely manner and we saw that an apology was given where this was appropriate.

Staff were aware of the complaint procedures and the designated person who handled complaints. They told us learning from complaints was shared through meetings. We saw evidence that all staff had received information governance and confidentiality training as a result of a complaint.

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 vision to deliver high quality, personal care to patients within the local community. There was no formal documented mission statement but this vision was evident during our inspection. The staff at the practice shared a desire to provide patients with a safe and caring service where patients were treated with dignity and respect, and involved in decisions.

The partners met quarterly for a strategy meeting and we heard about their strategic plans for the future.

Governance arrangements

There were clearly identified areas of lead responsibility for areas such as fire, health and safety, infection control, child safeguarding and adult safeguarding, complaints, clinical governance and data protection. There was also an identified staff member in each surgery for health and safety, fire safety, accidents and complaints.

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a number of these policies and procedures and saw these had been reviewed regularly and were up to date.

The practice had good arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. The practice did not have a risk log. The practice manager advised that any risks that were identified were raised immediately or during their weekly meeting with the managing partner and if necessary were escalated by email to the partners or discussed at the next fortnightly partners meeting.

Leadership, openness and transparency

We were shown a clear leadership structure, with teams and their team leaders reporting to the practice manager who in turn reported to the managing partner or the partners. There were named members of staff in lead roles. There was a lead nurse for infection control and the managing partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They told us that they felt valued, well supported and knew who to go to in the practice with any concerns. During our inspection we saw that staff were comfortable seeking advice and support from the GPs, practice manager and nursing team.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had conducted three patient surveys in the last 12 months. These included an individual GP survey, an administration survey and a survey of the Patient Participation Group (PPG). The PPG is an online forum made up of patients who have agreed to be contacted by the practice to give their views and feedback on how services could be improved.

The practice had responded to the findings of the latest and previous surveys. For example, an alternative local cost telephone number was available, rather than the more costly 0844 number previously used. In addition patient feedback was being obtained from the promotion of the NHS choices website. However we noted that the practice did not respond to the feedback received from NHS choices.

Practice staff were aware of the demand on GP appointments and had employed an emergency care practitioner and a nurse practitioner in order to help ease demand. They had recently set up a sit and wait service so patients with an urgent need would be seen the same day. They were aware that was not suitable for some patients so they also undertook telephone consultations. We found the practice was being as responsive as possible to meet patient needs using the staffing resources they had available.

The practice actively encouraged feedback from patients. There were posters and information on the practice website informing patients about the patient participation group and how to join. They also had suggestion boxes in the two practices that we visited and we were told they had a suggestion box in Kedington Surgery as well. Members of the patient group said that they were consulted by the practice in relation to patient priorities but they did not feel they had an active role.

GPs, nurses and administrative told us that the practice had an open culture where they felt safe and able to raise

Are services well-led?

Good

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

concerns. The practice had a whistle blowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with were aware of the whistle blowing policy and how to access it.

Management lead through learning and improvement

There was a process in place for the learning from significant events and complaints to be shared amongst the practice staff. However the documentation of the learning could be improved to ensure that changes to practice are made explicit, especially for staff who are not able to attend the meetings.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring and appraisals had been completed. Staff told us that the practice was very supportive of training and we saw evidence of this in the staff files we looked at.

The migration to the new computer system had been project managed by the practice manager. Staff spoke very positively about the management of the migration to the new clinical system and the training provided. We inspected the practice three weeks after the migration and all the staff seemed to be managing well with the basic aspects of the system, which reflected positively on the quality of the management of the migration.