Orchard Street Medical Practice - White

Quality Report

Orchard Street Medical Practice - White
Orchard Street Health Centre
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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

We carried out an announced comprehensive inspection at Orchard Medical Practice on 12 March 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, caring, responsive and effective services and for being well led. It was also good for providing services for older people, people with long term conditions, families, children and babies, working age people, people whose circumstances make them vulnerable and people experiencing poor mental health.

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

- Systems were in place for the learning and improvement from safety incidents. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning from internal and external incidents were evident.
- The staff at the practice demonstrated sound knowledge and understanding in relation to their practice population. A multi-disciplinary team approach to care was evident.
- All staff had a good awareness of the needs of patients whose circumstances made the vulnerable. We saw numerous examples of the proactive and person centred approach for individual patients. The practice were proactive in identifying and providing additional support to patients and in working with other agencies. We saw how people had been supported to maintain their independence and to live at home and access community and voluntary services. This helped ensure their welfare.
- Feedback we received from patients on the day of the inspection was generally positive. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available to patients.

Summary of findings

- Patients' needs were assessed and care was planned and delivered following best practice guidance. The practice had a good skill mix of clinical and non-clinical staff.
- There were shared values across all staff groups and staff told us they felt supported by the management team.

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

Importantly the provider should

- Consider the frequency of infection control audits and training.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, reviewed and addressed. There were enough staff to keep patients safe.

Risks to patients were generally assessed and well managed. However some risk assessments/audits did not have a schedule for review. Systems for checking fire equipment were in place.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were generally at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence, which was available on the practice's IT system. Patients' needs were assessed and care was planned and delivered in line with current legislation, we saw that care plans were in place to support this. Staff had access to training appropriate to their roles and further training was planned to meet these needs. The practice manager and staff we spoke with said that annual appraisals were completed and training needs were discussed.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients spoken with on the day of the inspection said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We received 29 comment cards, completed by patients. Feedback generally reflected that patients felt they were treated with dignity and respect. We saw that staff treated patients appropriately with kindness and respect, and understood the importance of patient confidentiality.

There were a large number of patients whose first language was not English. There were additional languages spoken by practice staff reflective of the languages of the patients and a translation service available.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Generally patients we spoke with on the day said they found it easy to make an appointment

Summary of findings

with a named GP, with urgent appointments available the same day. Comment cards, which had been completed by patients also reflected this view. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available in reception, however patients had to ask reception for a complaints form. We saw that the practice had responded appropriately to complaints they had received.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy which was shared by the staff we spoke with. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held governance meetings. There were systems in place to monitor and improve quality. The practice sought feedback from staff and patients, which it acted on. There was an active patient participation group (PPG) who worked with the practice to identify areas for further improvement.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice had a lower percentage of patients over 75 compared to other practices in the local clinical commissioning group (CCG). Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

Each patient over 75 had a named GP for continuity of care. The practice offered proactive, personalised care to meet the needs of the older people in its population and demonstrated a multi-disciplinary team approach to care planning for older people. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The staff we spoke with demonstrated their knowledge and understanding in relation to safeguarding vulnerable adults. We saw good examples of the proactive approach of the practice to support more vulnerable older people in the local community.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There was leadership in specific clinical areas for example, diabetes and chronic obstructive pulmonary disease (COPD). Data showed that patients with long term conditions received reviews of their care, treatment and medication. Longer appointments and coordinated home visits were available when needed.

We saw an example of how the lead for diabetes had produced in house guidance for diagnosis and management, using appropriate national guidance. They told us that they worked alongside the practice nurses who supported this work; this allowed the practice greater focus on specific conditions.

The practice was aware of patients at risk of an unplanned admission to hospital and demonstrated a multi-disciplinary team approach to care planning for patients with long term conditions.

We looked at the national patient survey data published in January 2015. Patients were asked if they had enough support to help manage their long term condition. Of those responding, 71% were positive. This response was above the CCG and the national average.

Summary of findings

Families, children and young people

Good

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

There was a named safeguarding lead at the practice. The staff we spoke with demonstrated knowledge and understanding in relation to safeguarding children and were aware of their responsibilities to report any concerns.

Saturday morning GP and nurse clinics were held to improve access to appointments to families where patients may be in work or education. We were told that some after school appointments were reserved for children.

We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. The practice promoted well person checks, screening, sexual health and family planning.

A university was located near to the practice. In order to promote the services available at the practice staff attended fresher's week to encourage new students to register with the practice.

Saturday morning GP and nurse clinics were held to improve access to patients in work and education.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

There was a holistic approach to care and support for people whose circumstances may make them vulnerable. We saw examples of a practice approach to identifying and providing additional support for example working closely with social care colleagues to support patients requiring accommodation. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Patients were supported to maintain their independence. Details of how to access various support groups and voluntary organisations were available on the practice website.

Summary of findings

The practice recognised patients whose circumstances may make them vulnerable, for example those who were homeless and those who had experienced drug and alcohol misuse. We received feedback from a patient who described their positive experience of the care and support received from the practice whilst homeless.

Longer appointments were available for patients with a learning disability, mental health needs and patients who may have difficulties with communication.

The staff we spoke with demonstrated their knowledge and understanding in relation to safeguarding vulnerable patients. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

We saw examples of case reviews which had been completed at the practice. These reviews looked at clinical events and reflected on the clinical care, maintaining good medical practice, relationships with patents and colleagues and the overall outcome in order to ensure appropriate care and treatment had been provided and to identify areas for further improvement. Two of the reviews we saw had looked at the care of a vulnerable patient.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and we saw that this information was available on the practice website.

The practice facilitated a memory clinic attended jointly by a consultant specialising in dementia care and a GP from the practice.

The practice provided us with examples of anonymised care plans which demonstrated positive outcomes

for patients. We saw a selection of care plans for patients over 75 years of age which had considered and involved external health care professionals, for example referrals to the memory clinic for patients who may have dementia.

Summary of findings

What people who use the service say

We spoke with 10 patients, who varied in age and clinical need, during our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They informed us that staff were polite, helpful and knowledgeable about their needs.

Prior to the inspection we had provided the practice with a comments box and cards to enable patients to tell us about their care. We received 29 completed comment cards left at the practice prior to the inspection. Generally comments received were positive. The theme from the cards was of a caring, professional and well organised practice. Five cards were less positive however there was no theme to these comments.

The practice had an active Patient Participation Group (PPG). PPGs are a way for patients and practices to work together to improve services and promote quality care. We met with four members of the group on the day of the inspection. They told us that they met with the practice approximately four times per year. They said they the practice sought their views and ideas in relation to improvements and acted upon them.

We looked at the results from the national GP patient satisfaction survey published in January 2105. Results showed that 85% of respondents would definitely or probably recommend the practice. The proportion of respondents to the GP patient survey who described their overall experience of the surgery as good or very good was 92%. The number of positive responses to both questions was above the local and national average.

Areas for improvement

Action the service SHOULD take to improve

- Consider the frequency of infection control audits and training.

Orchard Street Medical Practice - White

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspection manager. The team included a GP specialist advisor, a second CQC inspection manager and practice manager specialist advisor.

Background to Orchard Street Medical Practice - White

Orchard Street Medical practice is part of the NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG). The practice is registered with the Care Quality Commission to provide primary medical services. The practice has a primary medical service (PMS) contract with NHS England. Under the PMS contract the practice is required to provide essential services to patients who are ill and includes chronic disease management and end of life care. The practice is located in a purpose built health centre which it shares with one other practice. The practice has a registered list size of approximately 13,500 patients. The area served by the practice has seen a large population growth over the last decade.

The practice is open 8am to 6.30pm on Mondays to Friday. The practice opens for extended hours on Saturday mornings 8.30am to 1pm. The practice has opted out of providing out-of-hours services to their own patients. During the out of hours period patients receive primary medical services from Care UK.

The practice is run by two partners and six salaried GPs. Other practice staff consists of a practice manager, an advanced nurse practitioner, four practice nurses, three health care assistants supported by a reception and administration team.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 March 2015. During our visit we spoke with a range of staff, for example GPs, practice manager, members of the nursing and administration team. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed anonymised personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

We saw that the practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns. The online process for reporting incidents was readily available to staff.

We reviewed the documented incident reports and complaints. Records showed that learning outcomes were identified and shared with the appropriate staff groups. We saw minutes of meetings where significant events and incidents were discussed and action plans were produced and instigated. This showed the practice had managed safety and incidents consistently over time and so could show evidence of a safe track record over the long term

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records of significant events were made available to us. The records demonstrated that significant events had been discussed within the practice. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff explained the practice process for reporting incidents. They showed us incident forms on the practice intranet site which, when completed were sent to the practice manager. The incidents we viewed had been completed appropriately with evidence of action taken as a result.

National patient safety alerts were disseminated by the practice manager to practice staff. We saw that recent alerts were displayed in the practice.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff, including GPs had received relevant role specific training in safeguarding. The practice manager was aware of the staff who had not completed the requiring training. They gave assurance that this training had been scheduled. We asked members of medical, nursing and administrative staff about their knowledge and understanding of safeguarding. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and outside of normal hours.

Weekly clinical meeting were held where the safeguarding of children and vulnerable adults was discussed. We were given an example of concerns identified by reception staff and the actions that had been taken following the concern being raised. There was a system to highlight vulnerable patients on the practice's electronic records.

There was a chaperone policy in place; details of this were included in the practice welcome leaflet and on the internet. There was information in the waiting rooms and at the reception desk advising patients of this facility. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Some staff had been trained to be a chaperone, this included receptionists. The staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice manager told us that they were aware that further training for all staff acting as a chaperone was required.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were in date and appropriately stored.

There was Department of Health (DoH) guidance on ordering, storing and handling vaccines available to staff. Temperature checks were in place for ensuring that medicines were kept at the required temperature. We saw that medicines had been stored appropriately. To ensure safety, we were told that children's vaccines and travel vaccines were stored separately.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directions and evidence that the nurse, whose file we checked had received an update to training to administer vaccines.

We were told that each patient had a named GP who had overall responsibility for the management of care and welfare which would include medication reviews and

repeat prescribing. We saw examples of appropriate reviews of medication. There were designated staff employed for overseeing the management of repeat prescriptions, they were knowledgeable regarding their roles and responsibilities. All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescriptions and kept securely at all times.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked six anonymised patient records which confirmed that the procedure was being followed.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw there were cleaning schedules in place and cleaning records were kept, however the requirements for the frequency of cleaning was not clear.

The practice had a newly appointed lead for infection control who had undertaken basic infection control training. They had not received additional training to enable them to provide advice on the practice infection control policy and carry out staff training. Not all staff had received infection control training although the practice identified that this was required annually. We saw evidence that there has been some monitoring of infection control however there had been no formal audit completed.

Infection control policies and supporting procedures were available for staff to refer to. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was a central point for the storage of gloves and aprons in treatment rooms. There was a contract in place for the appropriate disposal of waste.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Guidance was also available for the safe use and disposal of sharps, for example syringes.

The practice had a system in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). The practice manager told us that a risk assessment was scheduled two yearly. They explained the process the practice had in place for carrying out regular checks to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. The nurse had single use equipment. They told us that all equipment was tested and maintained regularly. There was a schedule of equipment checks with most equipment being up to date and displayed stickers indicating the last testing date. We also saw evidence of calibration of most of the relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. There were items that, during the last testing, had not been included. The practice manager was aware of this and had taken action to address this.

Staffing and recruitment

We looked at the recruitment records of four staff members. Two were long standing staff members and two newly recruited. The records for the newly appointed staff member contained evidence that appropriate recruitment checks had been undertaken prior to employment, for example references. Where the staff member was a nurse we saw that registration with the appropriate professional body had been confirmed.

The practice manager told us that it was practice policy to risk assess all staff and when necessary complete a criminal records checks through the Disclosure and Barring Service (DBS). They told us that DBS checks were completed for all clinical staff routinely. Non-clinical staff, who may be asked to accompany a nurse on home visits or act as a chaperone would also have a DBS check completed. The staff files we looked at contained DBS checks when appropriate.

We saw that arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Good

Are services safe?

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 medicines management, staffing levels, dealing with emergencies and equipment. The practice also had a health and safety policy.

There had been a risk assessment of the kitchen area undertaken in September 2013; however there was no overall environmental risk log in place to ensure risks had been assessed and mitigating actions taken to reduce and manage the risk. Checks were recorded for the testing of fire alarms and door releases. However a fire risk assessment had not been completed since 2009. The provider told us that reviews of this assessment had taken place, however there had been no changes at the practice in this time. We saw evidence that arrangements had been made for an independent fie risk assessment to be completed in March 2015.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that the staff whose files we viewed had received training in basic life support. A training update, for all staff had been scheduled for April 2015. Fire safety training was recorded as being completed. We saw a signature sheet to show most staff had attended the training which had been specifically tailored to the practice.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Details of the location of emergency medicines and equipment were also included in the information leaflet given to new doctors when they joined the practice. Emergency medicines were available in a secure area of the practice and all staff knew of their location.

A disaster recovery and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Potential risk had been recorded and recovery action identified. Risks identified included fire, theft and power failure. The document contained relevant contact details for staff to refer to. For example, contact details of a heating company if the heating system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) which was readily accessible on the practice's IT system and from local commissioners. We saw minutes of practice clinical and multi-disciplinary meetings where new guidelines were discussed for example the new guidance for atrial fibrillation management. This is a heart condition that causes irregular or abnormally fast heart rate.

The staff we spoke with and the evidence we reviewed confirmed that actions and processes in place were designed to ensure that each patient received support to achieve the best health outcome for them. For example we saw a care plan for the avoidance of an unplanned admission to hospital which was appropriate and beneficial to the patient. The practice provided us with examples of anonymised care plans which demonstrated positive outcomes for patients. We saw a selection of care plans for patients over 75 years of age which had considered and involved external health care professionals, for example referrals to the memory clinic for patients who may have dementia.

We found, from our discussions with the GPs, that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We saw that there were GP leads in specialist areas such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease. (Chronic Obstructive Pulmonary Disease (COPD) is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections.) We saw an example of how the lead for diabetes had produced in house guidance for the diagnosis and management using appropriate national guidance. They told us that they worked alongside the practice nurses who supported this work; this allowed the practice greater focus on specific conditions.

Data from the local Clinical Commissioning Group (CCG) of the practice's performance for example in relation to prescribing, attendance at accident and emergency etc. was made available to us. We saw that the data was comparable to similar practices.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. We were given examples of how the practice managed and supported its diverse population, for example when patients first language was not English

There were designated staff employed for overseeing the management of repeat prescriptions, they were knowledgeable regarding their roles and responsibilities. They explained that if a prescription was requested post review date GP advice would be sort, and the GP would make a decision as to the action to take. The staff focussed on ensuring medicine reviews took place alongside other reviews of their health.

Management, monitoring and improving outcomes for people

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example in relation to prescribing, accident and emergency attendance and emergency admissions.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection. There was a lead GP and practice nurse for diabetes. There was ongoing liaison with the hospital regarding diabetic care. There was evidence from audits of improved care for example in patients who were diabetic. We were told by the practice manager that a GP at the practice had undertaken additional research and learning in relation to diabetes care. Their findings had been presented to all clinicians to further support patients diagnosed with this condition.

The GPs told us clinical audits were often linked to medicines management information. The practice showed us 12 clinical audits that had been undertaken in the last

Good

Are services effective?

(for example, treatment is effective)

two years. A range of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example reduced antibiotic prescribing in treatment of tonsillitis. Other examples included audits to confirm that the GPs, who undertook minor surgical procedures, were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The practice used the information collected for the Quality and Outcome Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

We were told that each patient had a named GP who had overall responsibility for the management of care and welfare which would include medication reviews and repeat prescribing. We saw examples of appropriate reviews of medication. We saw that there were 184 patients who fit the criteria for a shingles vaccine. The practice had been proactive in in offering this vaccine and 130 had been administered.

The team made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. One nurse we spoke with told us she had fortnightly clinical supervision with one of the GP's during which they reviewed patient care. Staff spoke positively about the culture in the practice around audit and quality improvement.

There was a process in place for repeat prescribing with staff regularly checking that patients receiving repeat prescriptions had been reviewed by the GP. There was evidence that the practice did not routinely issue repeat prescriptions without first reviewing a patient. Staff checked that routine health checks were completed for long-term conditions such as diabetes and were proactive in ensuring these checks were coordinated with medication reviews.

For patients receiving end of life care, plans were in place and shared with the out of hour's team. The practice also worked with agencies such as the Macmillan nurses. The practice held a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

We saw examples of case reviews which had been completed at the practice. These reviews looked at clinical events and reflected on the clinical care, maintaining good medical practice, relationships with patients and colleagues and the overall outcome. Two of the reviews we saw had looked at the care of a vulnerable patient.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff had received training appropriate to their role, such as annual basic life support. We noted a good skill mix among the doctors. The practice manager told us that all GPs were up to date with their yearly continuing professional development requirements, and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). In addition to revalidation salaried GP all have practice level appraisal by a senior partner and practice manager. The appraisals reviewed development needs and performance.

The practice manager told us that staff undertook annual appraisals that identified learning needs. Our interviews with staff confirmed that the practice was proactive in providing training. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the registrar we spoke with. They told us that the staff at the practice were very supportive. Trainees were allocated a named trainer however we were told that all GPs were involved in the support for each individual registrar.

A leaflet had been produced for all new staff. We saw an information leaflet for doctors joining the practice. Details included a list of staff, their roles and extension numbers, together with guidance on the clinical system and the practice process for referrals.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and support patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice attended the CCG monthly clinical meetings and were active partners of the local GP federation.

Staff groups had responsibilities for receiving correspondence and acting on any issues arising from communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. The GPs were able to explain to us how results and information were managed in the practice. If it was electronic it was sent directly to the GP, and if in paper copy it was scanned first. Information was coded by the relevant administrative staff and this was then double checked by the GP, who was then responsible for taking any action.

The practice told us that they held multidisciplinary team meetings every four to six weeks to discuss patients with complex needs, for example those with end of life care needs or children on the at risk register. District nurses, social workers, and palliative care nurses were invited to these meetings for decisions about care planning. A GP told is that the recordings of these meetings were documented in the patient's shared care record.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. For example we spoke with a GP registrar who spoke positively about their experience of support from both their trainer and clinical and non-clinical colleagues.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, as did the community health service provider, to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Electronic systems were also in place for making referrals, and the practice had made over 1000 referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, the practice manager told us that the practice was able to provide a printed copy of a summary record for patient to take with them to A&E. When appropriate the practice shared information with the out of hours care provider, for example those receiving end of life care.

Consent to care and treatment

We found that staff we spoke with were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

We reviewed the results on the national patient survey and 75% of patients responding said the last GP they saw or spoke to was good at involving them in decisions about their care. This was in line with the CCG and national average. The same question was asked in relation to the nursing staff, 79% responded positively. This was above the CCG and national average.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans. The practice manager told us that patients, and if appropriate carers, did not routinely take up the offer to be involved in the development of these plans.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures. A record of the relevant risks, benefits and complications of the procedure were included.

Health promotion and prevention

The practice had a high number of patients who were not permanent residents in the local area. It was practice policy to offer a health check with a health care assistant or a practice nurse to all new patients registering with the practice. The GP was informed of all health concerns to follow up as appropriate. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The GPs said that they tried to address all issues related to a patient when they attended an appointment and if necessary a further appointment would be made. For example, by offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

The practice offered NHS Health Checks to all its patients aged 40 to 75 years and were proactive in offering this service.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. A GP told us that all had been offered an annual physical health check; approximately 25% of these had been completed. The practice identified the smoking status of patients over the age of 16 and actively offered smoking cessation clinics to these patients. The practice had successfully supported 76 patients to stop smoking within the last 12 months. We saw that the practice had achieved a first place award (for the Suffolk area) for three years for supporting patients to stop smoking. Weight control, well man and well woman clinics were also available. These were advertised on the practice website.

The practice's performance for cervical smear uptake was 80%, which was in line than others in the CCG area. The practice manager told us that the practice aspired to achieve an 85 to 90% uptake. The practice were proactive in ensuring that all patients were offered this service ensuring that information was available in alternative languages.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Details were available to patients on the practice website.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction from the national GP patient survey published January 2015. The results showed that 94% of respondents found the reception staff very or fairly helpful. This was above the local and national average. When asked 81% of patients responding said that the last nurse they saw was good or very good at treating them with care and concern. This was slightly below the CCG average of 83%. The practice had responded by appointing additional nurses and increasing nurse appointments.

In relation to the GPs, 84% responded positively. This was in line with the CCG average. The proportion of respondents to the GP patient survey who described their overall experience of the surgery as good or very good was 92%. This was above the CCG average of 87% and the national average of 86%. The practice received positive patient feedback in relation to consultations with doctors with 87% of practice respondents saying the GP was good at listening to them and 86% saying the GP gave them enough time.

We saw the results from a survey of 100 patients undertaken by the practice's patient participation group (PPG) in 2013; these results were available on the practice website. We saw a patient participation survey dated February 2015. The analysis and action plan following this survey were not yet available at the time of the inspection.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 29 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and that staff treated them with dignity and respect. Four comments were less positive but there were no common themes to these. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We saw that all consultations and treatments were carried out in the privacy of a consulting room. Privacy 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a triage system in place for patients requiring urgent appointments. Reception staff asked patients key questions before passing the information to a clinician to make a decision. We received some feedback, from two patients who did not think this was appropriate. We asked the reception staff how they ensured patients were comfortable with sharing this information; they were able to give appropriate examples.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed 75% patients responded positively to questions about the GP involving them in decisions about their care. This was generally in line with the CCG and national average. 79% of patients responded positively was asked the same question about the nursing team, the satisfaction rating was higher than the CCG and national average.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also generally positive and aligned with these views.

We were told that there were over 70 different languages spoken by the patients registered at the practice. Staff told us that there was multi lingual staff working at the practice and that translation services were available for patients who did not have English as a first language.

The practice provided us with examples of anonymised care plans which demonstrated positive outcomes for patients. We saw a selection of care plans for patients over 75 years of age which had considered and involved external health care professionals, for example referrals to the memory clinic for patients who may have dementia.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were generally positive about the care and support provided by the practice. For example, 84% of respondents to the national GP patient survey said that the GP was good at giving them enough time. 84% of patients responded positively was asked the same question in relation to nursing staff. When asked if they were treated with care and concern, 86% of patients responded positively in relation to the GPs and 81% in relation to the nursing team.

Notices in the patient waiting room, on the TV screen and practice website also told patients how to access a number of support groups and organisations. The practice manager told us that the messages displayed on the TV screen were changed depending on patient needs and season, for example flu vaccines were prompted at the appropriate time of year. The practice's computer system alerted GPs if a patient was also a carer. This information was used to further support this group of patients for example to proactively call patients for flu vaccines when appropriate to do so.

The practice manager told us that Suffolk Carers Group attended the practice regularly. They had a display stand in the waiting area providing useful information to carers.

Staff told us that if families had suffered bereavement, a GP would make contact with them. We were told that some patients or family members may be sent a letter and others receive a telephone call.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

At the start of our inspection a GP gave us a presentation about the practice. This included information about the needs of the practice population.

The needs of the practice population were clearly understood and systems were in place to address identified needs in the way services were delivered. We were shown examples of a holistic approach to care and support for people whose circumstances may make them vulnerable. We saw examples of additional support such as working closely with social care colleagues to support patients requiring accommodation.

The practice identified the smoking status of patients over the age of 16 and actively offered smoking cessation clinics to these patients. The practice had successfully supported 76 patients to stop smoking within the last 12 months.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). We met with four members of the group. They told us about suggested improvements that they had made, for example installing a television in the waiting room to display health information. PPG members told us they were actively involved in discussions relating to access and how the practice could continuously improve its service. To help improve access the group had suggested advertising the number of missed appointments at the practice each month. The practice had put both of these suggestions in place.

Tackling inequity and promoting equality

We were told that there were over 70 different languages spoken by the patients registered at the practice. Staff told us that there were multi-lingual staff working at the practice and that translation services were available for patients who did not have English as a first language. One nurse that we spoke with told us that the use of language line had been covered during their induction to the practice.

Some health promotion information was available in other languages for example cervical screening. There was the facility to translate the practice website into a number of different languages.

The premises and services were appropriate to meet the needs of patient with disabilities. For example there were automatic doors at the front and rear of the premises and clinics held on upper floors could be accessed via a passenger lift in the practice. For patients with a hearing impairment there was a hearing loop available.

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

A GP told us that to ensure that practice staff delivered quality patient centred care to all patients the practice was in the process of providing appropriate training. They told us that to further support lesbian, gay, bisexual and transgender (LGBT) patients some staff had received additional training. The practice manager told us that GPs, nurses and non-clinical staff had received this training.

Access to the service

Appointments were available from 8.30 am to 6.30 pm on weekdays. Pre bookable appointments were also available on Saturdays between 8.30 am and 12.30 pm. Same day appointments were available when necessary.

We looked at the results of the national GP patient survey published in January 2015. When asked about satisfaction with opening hours 73% were either very or fairly satisfied. This was slightly below the CCG and national average.

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. The website advised patients that telephone advice was also available if required.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. The feedback we received from talking to patients and comment cards was that generally people were satisfied with the appointment process. Results from the national GP patient survey showed that 95% of respondents were able to get an appointment to see or speak to someone the last time they tried. This was above the CCG average of 90% and the national average of 86%. 92% of those responding said that the last appointment they got was convenient. 54% said that saw or spoke to a GP or nurse the same day, this was 10% above the CCG average.

Listening and learning from concerns and complaints

The practice had a system and policy in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice.

Patients were provided with a leaflet which gave guidance on how to make a complaint; this included external agencies that patients could contact if they wished. We saw that information was available on the practice website to help patients understand the complaints system. Information displayed in the waiting area advised patients to obtain a complaints leaflet from reception if they wished to complain.

The practice held a log of all written complaints; this allowed them to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Verbal complaints were logged in a diary; it was not clear if these complaints had been subject to the same investigation and response as the written complaint or been included in any trend analysis. The practice manager recognised the benefits to aligning these two processes.

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

A GP partner told us that the practice has a clear vision to provide safe, effective and evidence based healthcare to all of their patients. We spoke with a selection of clinical and non-clinical staff and they all demonstrated shared values and knew what their responsibilities were in relation to these. Discussions with GP partners and the management team demonstrated that the practice recognised the challenges faced with an increasing and diverse practice population and were proactive in meeting and addressing the challenges.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at a selection of policies and procedures which were practice specific and had been reviewed. The practice had arrangements for identifying, recording and managing risks and a system for the management of complaints.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance.. QOF is a voluntary incentive scheme for GP practices in the UK. The QOF data for this practice showed it was generally performing in line with national standards.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example atrial fibrillation (a heart condition that causes irregular or abnormally fast heart rate) took patients off aspirin and on to the new anti-coagulants and reduced antibiotics in treatment of tonsillitis.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. One nurse we spoke with told us she had fortnightly clinical supervision with one of the GP's during which they reviewed patient care. Staff spoke positively about the culture in the practice around audit and quality improvement.

Leadership, openness and transparency

A GP partner told us that there was a culture of learning and engagement and a whole team approach to patient care. We saw that team meetings were held and minutes were produced. Informal meetings 'huddles' took place more frequently, the practice manager told us that notes from these meeting were emailed to colleagues where appropriate. We were shown an example of this. Staff told us that felt supported within the practice and they had the opportunity to raise issues at with the management team.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We saw that polices were available to all staff.

To ensure that patients knew the names of all GPs at the practice there was a practice leaflet available which included photographs of the GP team.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) with approximately six members who regularly attended meetings. A senior partner told us that there were approximately 140 members who they communicated with on a regular basis. PPGs are a way for patients and practices to work together to improve services and promote quality care. The group told us that they met quarterly and minutes were taken at the meeting and these were made available to members. They told us about suggested improvements that they had made, for example installing a television in the waiting room to display health information. PPG members told us they were actively involved in discussions relating to access and how the practice could continuously improve its service. To help improve access the group had suggested advertising the number of missed appointments at the practice each month. The practice had put both of these suggestions in place.

The practice had completed a recent patient satisfaction survey; at the time of this inspection the analysis of the results had not been completed.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that regular appraisals took place; staff told us that personal development was an agenda item during appraisals.

The practice was a training practice for doctors who were training to be qualified as GPs. Support was provided by a senior GP. We received positive feedback from the registrar we spoke with. They told us that the staff at the practice was very supportive. Trainees were allocated a named trainer however we were told that all doctors were involved in the support for each individual registrar.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.