Burlington Road 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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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection report published 6 March 2017 - Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Burlington Road Surgery on 26 February 2018 as part of our regulatory functions.

At this inspection we found:

- The practice had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the practice learned from them and improved their processes.
- The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines. The clinical team met regularly to keep updated, share learning and review patients.
- The practice had developed a number of initiatives to improve the service provided to patients. For example, the General Practitioner Personal Assistant team; a dedicated clinical administration team.
- Clinicians worked in the multidisciplinary hub to ensure that patients were effectively triaged, assessed and directed to the most appropriate clinician with the right skill set, who then undertook further assessment and coordination as appropriate. Flexible appointment times were offered throughout the day.
- The practice had a strong focus on the training, development and support of all staff. Opportunities for learning were scheduled on a daily basis through the

Summary of findings

work undertaken in the multidisciplinary hub and a GP partner was always available for support and advice. Effective processes were in place for reviewing and developing the work of locum GPs, advanced nurse practitioners and nursing staff.

- The practice's uptake for cervical screening was 61%, which was below the 80% coverage target for the national screening programme. The practice were aware of this and had taken some actions to improve the uptake. They had a dedicated nurse responsible for improving the uptake of cervical screening of women who were vulnerable due to language barriers, fear of the procedure or other social barriers. 2017/2018 unverified data showed the practice had achieved 70% so far.
- Staff involved and treated people with compassion, kindness, dignity and respect. All staff had received equality and diversity training. The practice were aware of the needs of the patient population and had health information packs available in four different languages.
- Patients generally found the appointment system easy to use and reported they were able to access care at the right time, although some patients reported dissatisfaction with the length of time taken to answer the telephone. The practice monitored feedback from the National GP Patient Survey and had implemented actions in response to the feedback.
- The practice were in the process of establishing a patient population group and were continuing work to identify patient representatives from the minority ethnic groups to ensure the views of these patients were obtained. They had decided to wait until the merger with another local practice had been completed so that there would be one patient participation group.
- Information on the complaints process was available for patients at the practice and on the practice's website. There was an effective process for responding to, investigating and learning from complaints and responses to patients were timely.
- Staff told us they were happy to work at the practice, received training and support for their role and were encouraged to raise concerns and share their views.
- There was strong leadership; staff had lead roles and responsibilities. Effective governance processes were in place for ensuring that systems were safe and responded to the needs of patients and for monitoring performance.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The practice was a teaching practice for medical students and a training practice for qualified doctors training to become GPs. The practice offered opportunities for A level students who had been unsuccessful in their medical school application, to work as a healthcare assistant for one year. The practice advised that of the seven staff who have undertaken this opportunity, all of them have since gained entry to medical school.

The areas where the provider **should** make improvements are:

- Establish the patient participation group.
- Monitor and improve the uptake of cervical screening.

We saw one area of outstanding practice:

- The practice had set up a 'multidisciplinary hub' in 2015, where clinicians, including advanced nurse practitioners, primary care associates and GPs worked together in the same room, led by a GP partner, to ensure that patients were effectively triaged, assessed and directed to the most appropriate clinician with the right skill set. Further assessment was undertaken and care was coordinated by one clinician as appropriate to the patient's needs, with GP oversight. This was for high risk patients but the service had flexibility to meet the needs of all patients with urgent and routine needs, depending on the demand. Flexible appointment times were offered throughout the day. Training was provided to the staff working in the hub opportunistically, based on the cases which presented. An audit on the effectiveness of the hub was completed in November 2015, which demonstrated positive outcomes. Patients who were at high risk were not delayed in needing to attend the accident and emergency department, as they had instant access to a GP for assessment and advice. Patients were subsequently followed up by a clinician in the hub. Six hours of GP training time was made available to supervise clinical and non-clinical practice staff in the practice. Primary care associates received training and mentoring in real time without affecting

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or compromising patient access. Feedback on the first 100 cases that the primary care associate in the hub had managed, had been obtained from patients, carers, clinicians and care home managers in November 2015. This feedback showed 100% satisfaction with the assessment and management by the primary care associate who worked in the hub and 100% satisfaction with the speed of delivery of medicines. A review of home visit requests showed that following triage, 30% of requests did not need a home visit; 60% of those patients came to the practice for their appointment and 40% had a telephone consultation. This enabled resources to be directed at those with urgent needs.

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

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Areas for improvement

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

- Establish the patient participation group.
- Monitor and improve the uptake of cervical screening.

Outstanding practice

We saw one area of outstanding practice:

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- Feedback on the first 100 cases that the primary care associate in the hub had managed, had been obtained from patients, carers, clinicians and care home managers in November 2015. This feedback showed 100% satisfaction with the assessment and management by the primary care associate who worked in the hub and 100% satisfaction with the speed of delivery of medicines. A review of home visit requests showed that following triage, 30% of requests did not need a home visit; 60% of those patients came to the practice for their appointment and 40% had a telephone consultation. This enabled resources to be directed at those with urgent needs.

Burlington Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Burlington Road Surgery

- The name of the registered provider is Burlington Road Surgery. The practice address is 14 Burlington Road, Ipswich, Suffolk, IP1 2EU.
- The practice website is http://www.burlingtonprimarycare.co.uk
- The practice has a Personal Medical Services (PMS) contract with the local Clinical Commissioning Group (CCG).
- The practice is registered to provide diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.
- There are approximately 16,600 patients registered at the practice.
- The practice has six GP partners, (four male and two female) and one salaried GP (female). The nursing team includes three advanced nurse practitioners, all of whom are independent nurse prescribers, four practice nurses, two primary care associates and three healthcare assistants. They are supported by a dedicated clinician administration team. The practice manager is supported by three managers who oversee areas such as finance, human resources and information technology. There is also a dedicated prescription team, three medical secretaries and a team of reception staff. A multidisciplinary hub, led by a GP partner operates which facilitates flexible appointment times throughout the day.
- The practice is open between 8am and 6.30pm Monday to Friday. The practice
- has extended hours appointments from 7am to 8am Monday to Friday with GPs, advanced nurse practitioners and healthcare assistants and from 6.30pm to 7pm Monday to Friday with GPs.
- When the practice is closed, Care UK provides the out of hours service and patients are asked to call the NHS 111 service to access this service, or to dial 999 in the event of a life threatening emergency.
- The practice is a training practice, although there was no GP trainee placed at the practice at the time of the inspection. (A GP trainee is a qualified doctor who is training to become a GP).
- According to Public Health England data, the practice has an above average number of patients between the ages of 0-4, and a below average number of patients between the ages of 65 and 85, than the national average. Male and female life expectancy in this area is in line with the England average at 78 years for men and 83 years for women. Income deprivation affecting children is 23%, which is in line with the England average of 20% and above the CCG average of 13%. Income deprivation affecting older people is 21% which the same as the England average and above the CCG average of 13%. Just over 12% of patients are from minority ethnic groups.

Good

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice conducted safety risk assessments. Safety policies were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. The practice had written a policy booklet which all staff had a copy of; this included the main points of frequently used policies which included safeguarding. Safeguarding information displayed within the practice outlined clearly who to go to for further guidance. Staff were trained in safeguarding to a level appropriate to their role. GPs and nurses were trained in child safeguarding to level three. There was a lead GP, deputy lead GP and an administration lead for safeguarding.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Children at risk and vulnerable adults were identified and discussed on a monthly basis and GP support was always available if immediate concerns were identified. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, at recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. All staff had received basic life support and anaphylaxis training, with the exception of one receptionist, which had been booked.
- There was an effective system to manage infection prevention and control. Some actions had been taken following the previous infection control audit in June 2017. For example, cleaning schedules for the rooms used by advanced nurse practitioners were in place and cleaning had been completed and documented. The completion of the other actions was monitored by the infection control lead. Appropriate arrangements were in place for the cleaning of spilt body fluids and Hepatitis B records were maintained for staff.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The service had been designed so that it was able to be flexible. For example, there was capacity for urgent appointments through the emergency appointment clinic scheduled in the afternoon, through clinicians in the multidisciplinary hub and through additional GP appointments which could only be allocated by a clinician, until nearer the appointment time, when these could then be booked by a non clinician, if they were still available.
- There was an effective induction system for permanent and temporary staff tailored to their role. This included a locum induction pack for GP locums.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Guidelines were available for staff. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. The practice had set up a multidisciplinary hub, where clinicians worked together, led by a GP partner, to ensure that patients were effectively triaged, assessed and directed to the most appropriate clinician with the right skill set. There was always a dedicated GP partner based in the hub, who led this service. They discussed cases with other clinicians before patients were contacted and were able to listen in to phone calls and participate in the call if necessary.

Information to deliver safe care and treatment

Good

Are services safe?

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way. The practice had undertaken a two cycle audit of note taking by GP partners in 2016. The first audit showed that results were below the expected 90% standard in eight samples. The second cycle audit showed this had improved, with two samples being below the expected 90% standard. The practice planned to undertake this audit again.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters we reviewed included all of the necessary information and a system was in place to track that referrals had been received. This included two week wait suspected cancer referrals.

Appropriate and safe use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, emergency medicines and equipment minimised risks. Records were kept of checks on refrigerator temperatures and emergency equipment and medicines. The practice kept prescription stationery securely and monitored its use.
- The practice had a system in place to check that patients prescribed high risk medicines were monitored appropriately. High risk medicines, such as methotrexate, warfarin and lithium require regular blood monitoring before they are re-prescribed. The practice had a system for reviewing patients who were prescribed high risk medicines. We reviewed this system and a sample of the care records of patients prescribed methotrexate and lithium. We found appropriate monitoring was in place.
- Staff prescribed, administered and supplied medicines to patients and gave advice on medicines in line with current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- Patients from 12 care homes were registered with the practice; four of these care homes were aligned to the practice and five care homes received a weekly visit from a GP. We spoke with representatives from five of the care homes who confirmed that patients' medicines were prescribed and reviewed appropriately.

Track record on safety

The practice had a good track record on safety.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The practice had documented six significant events from April 2017 to the day of the inspection. Appropriate systems were in place for reviewing and investigating when things went wrong.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, the practice had improved the system for documenting current patient group directions (PGDs), monitoring the expiry date and ensuring they were appropriately signed. PGDs allow nurses to administer medicines in line with legislation. We also saw examples where significant events had involved external agencies and the practice had informed them of the errors in order that they could be addressed by the external organisation.
- There was a system for recording and acting on safety alerts, which included Medicines and Healthcare Regulatory Agency (MHRA) alerts. Safety alerts were logged, shared and initial searches were completed and the changes effected. The practice learned from external safety events and patient safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence based practice. The practice had developed a resource of all NICE guidance that was relevant to GP practice and this was available on the desktop of each computer in the practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients received a full assessment of their needs. This included their clinical needs and their mental and physical wellbeing. This was particularly evident in the work undertaken by clinicians in the multidisciplinary hub. We saw examples of patients' needs being assessed and services coordinated in order to meet those needs.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. For example, where appropriate, patients who had been seen following assessment by staff working in the multidisciplinary hub, were sent information by text message, which included actions to take if their condition deteriorated.

Older people:

- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis, dementia and heart failure were in line with the local and national averages.
- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. This included a review of medication. Reviews were undertaken by clinicians in the multidisciplinary hub and patient records were also reviewed at multidisciplinary team meetings.
- Older patients who were discharged from hospital were reviewed and any actions identified were followed up. This work was undertaken by clinicians in the multidisciplinary hub.

People with long-term conditions:

- Nationally reported data showed that outcomes for patients with long term conditions, including diabetes, asthma, Chronic Obstructive Pulmonary Disease (COPD), hypertension and atrial fibrillation were in line with the local and national averages.
- Advanced nurse practitioners had lead roles in diabetes, asthma and COPD. Their work was overseen by a GP.
- Patients with long-term conditions had a structured review at least annually, to check their health and medicines needs were being met. For patients with the most complex needs, the advanced nurse practitioners worked with other health and care professionals to deliver a coordinated package of care. Advanced nurse practitioners were able to commence insulin treatment for patients with diabetes, as appropriate.
- Patients with complex diabetes were referred to the specialist diabetes service, which held a clinic at the practice once a month. The practice identified patients at risk of developing diabetes, provided education and ensured they were recalled annually for a review.
- Staff who were responsible for the review of patients with long term conditions had received specific training.
- 100% of patients with long term conditions who were recorded as current smokers, had a record of an offer of support and treatment in the previous twelve months. This was above the Clinical Commissioning Group (CCG) and national average of 97%.
- The practice had two 24 hour blood pressure monitors and a 24 hour electro cardiogram monitor (ECG) which it loaned to patients to help investigate and manage their condition.

Families, children and young people:

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- We were told of positive examples of joint working with midwives and health visitors. Postnatal checks were completed for new mothers and this appointment was also used to check the babies.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake

Good

Are services effective?

(for example, treatment is effective)

rates for the vaccines given to one and two year olds were in line with the target percentage of 90% or above. For example, rates for the vaccines given to one year olds ranged from 95% to 96% and for two year olds ranged from 96% to 97%. Appropriate follow up of children who did not attend for their immunisations was in place.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 61%, which was below the 80% coverage target for the national screening programme. The practice were aware of this and had taken some actions to improve the uptake. They had a dedicated nurse responsible for improving the uptake of cervical screening of women who were vulnerable due to language barriers, fear of the procedure or other social barriers. Uptake was monitored by the management team. 2017/2018 unverified data showed the practice had achieved 70% so far.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks which included new patient checks and NHS health checks for patients aged 40-74. The practice had invited 531 patients for a NHS health check in the last 12 months and 278 had been completed. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- There was a lead GP for patients with a learning disability within the practice. Annual health assessments for people with a learning disability were undertaken by the practice nurse and overseen by a GP. The practice had 107 patients with a learning disability on the practice register who were eligible for a health assessment; 73 patients had received one. A further 18 health assessments were planned, 14 patients had not attended their appointment and continued to be followed up by the practice and two patients had recently registered and would be invited. Patients who did not attend were followed up by letter or telephone. Uptake was monitored by the management team.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability or mental health needs.

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

- 78% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was comparable to the CCG and national average of 84%. The exception reporting was 8%, which was the same as the CCG average and above the national average of 7%.
- 90% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the CCG average of 93% and the national average of 91%. The exception reporting was 29%, which was above the CCG average of 15% and the national average of 13%. The practice explained that this was due to difficulties with patient engagement. There was a process for patients to be contacted by letter and twice by telephone before they were excepted from the data. We reviewed this exception reporting and found it to be appropriate.
- 91% of patients who experienced poor mental health had received discussion and advice about alcohol consumption in the previous twelve months. This was the same as the CCG average and national average. The exception reporting was 23%, which was above the CCG average of 13% and the national average of 10%. There was a process for patients to be contacted by letter and twice by telephone before they were excepted from the data. We reviewed this exception reporting and found it to be appropriate.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Monitoring care and treatment

Good

Are services effective?

(for example, treatment is effective)

- The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.
- We reviewed a three cycle clinical audit for the treatment of new-born patients with an umbilical granuloma (a small growth of tissue that can form on a new-born's naval). The second audit found that the total number of patients treated by the appropriate clinician, a GP, increased from 80% to 100% and this had been maintained at the third audit. The second audit showed the correct treatment was given 50% of the time, compared with 60% at the first audit; however this had improved to 100% at the third audit. Identified action for improvement had been implemented.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had undertaken work to improve cancer outcomes. This included, for example, the production of an educational resource, a focus on preventative measures and significant event analysis of 12 cancer cases which were not diagnosed through the two week wait referral guidelines to identify learning and improve patient outcomes.

The most recent published Quality Outcome Framework (QOF) showed the practice's total achievement was 98% which was the same as the clinical commissioning group (CCG) average and above the national average of 96%. The overall exception reporting rate was 9%, which was the same as the CCG average and below the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- Performance for depression related indicators was 74%, which was below the CCG average of 94% and the national average of 93%. The exception reporting for depression was 31%, which was above the CCG average of 25% and the national average of 23%. 2017/2018 unverified data showed the practice had achieved 88% so far.
- Performance for cancer related indicators was 100% which was above the CCG and national average of 97%. The exception reporting rate was 8% which was below the CCG average of 30% and national average of 25%. The prevalence of cancer was 2% which was above the CCG average of 1% and in line with the national average. The practice explained that their performance and low exception reporting was due to the work they had undertaken as part of their cancer action plan.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet their needs. Staff were encouraged and given opportunities to develop. For example, two health care assistants were currently completing a foundation degree in healthcare practice. Up to date records of skills, qualifications and training were maintained.
- The practice provided staff with ongoing support. This included a GP partner available in the multidisciplinary hub for advice and support, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. Support and monitoring was in place for the nursing staff.
- The practice reviewed the competence of staff employed in advanced roles. An identified GP met with the advanced nurse practitioners individually, every one to two weeks to discuss clinical cases and review their referrals. The work of the primary care associates who worked in the multidisciplinary hub was led by a GP and their work was formally reviewed. For example, the first 100 cases that each primary care associate had worked on had been reviewed and additional learning identified. Feedback from patients, carers, clinicians and care home managers had also been obtained which showed 100% satisfaction with the assessment and management by the primary care associate and 100% satisfaction with the speed of delivery of medicines.
- The practice completed a clinical audit in 2017 of GP locum consultations, which included referral, assessment, prescribing, investigation and follow up. Results were above the 90% standard in three of the five areas. Feedback was given to the GP locums and information added to the locum pack in response to the

areas for learning which were identified. Audit of these areas was now completed on a weekly basis for new GP locums initially and then on a monthly basis and improvements had been demonstrated.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- The practice had established a General Practitioner Personal Assistant team. This dedicated team of trained non-clinical staff were responsible for monitoring patient related communications, results and follow up of patients and liaising directly with patients. The oversight of this work was undertaken by a GP.
- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice read coded patient choices in relation to their palliative care needs so that other services involved were able to see this on the patient's record. The practice had agreed a template to record appropriate information and this was used to form the basis of the review of palliative care patients at the multidisciplinary team meeting.
- The practice could demonstrate that they held multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The health care assistants offered a smoking cessation service to patients. This was available for patients to book at any time a health care assistant was working. The practice advised that they had won the 'Live Well Stop Smoking' award from OneLife Suffolk, for the previous five years for the highest number of patients who had stopped smoking. One Life Suffolk is an organisation contracted by Suffolk County Council with the aim to help local people live healthier lives.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking and keep antibiotics working campaigns.
- Health information packs were available in the waiting room in English, Polish, Romanian and Portuguese.
- 77% of females between the ages of 50 and 70 had been screened for breast cancer in the preceding 36 months. This was in line with the CCG average of 79% and the national average of 70%.
- 54% of patients had been screened for bowel cancer in the preceding 30 months. This was in line with the CCG average of 61% and the national average of 55%.
- **Consent to care and treatment**
- The practice obtained consent to care and treatment in line with legislation and guidance.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.
- One of the GPs at the practice undertook minor surgery, although they had not undertaken this for approximately one year due to a lack of demand. The minor surgery audit completed in 2016, showed that written consent had been obtained in 100% of cases and pathology results and actions, complication and infection rates were recorded.

Good

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, and social needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 19 patient Care Quality Commission comment cards we received were positive about the service being caring. All of the four patients we spoke with gave positive feedback in this area.
- We spoke with representatives from five of the care homes where patients were registered at the practice. We received positive feedback in relation to ensuring privacy was maintained and patients being treated with kindness and respect.
- The practice had reviewed the NHS Friends and Family Test (FFT) data from March 2017 to January 2018 and from 676 responses received, 87% of patients would recommend the practice. (The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed).

Results from the July 2017 national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 243 surveys were sent out and 90 were returned. This was a 37% response rate and represented below 1% of the patient population. Results were in line with local and national averages:

- 89% of patients who responded said the GP was good at listening to them compared with the Clinical Commissioning Group (CCG) average of 90% and the national average of 89%.
- 86% of patients who responded said the GP gave them enough time compared with the CCG average of 87% and the national average of 86%.
- 97% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and the national average of 95%.
- 85% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG and the national average of 86%.
- 94% of patients who responded said the nurse was good at listening to them compared to the CCG average of 94% and the national average of 91%.
- 94% of patients who responded said the nurse gave them enough time compared with the CCG average of 95% and the national average of 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 93% and the national average of 91%.
- 82% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 89% and the national average of 87%.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language and additional time was given for these appointments.
- Staff communicated with people in a way that they could understand, for example, easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers, through asking this on the new patient registration form and by inviting patients who were carers to register as

Good

Are services caring?

carers with the practice. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 272 patients as carers, which was just above 1.5% of the practice list.

- Staff told us that they considered the needs of carers when booking appointments for patients who were or had carers.
- Information was available for carers to signpost to sources of support and advice, for example, a local organisation called Suffolk Family Carers.
- Patients coded as carers were offered an influenza vaccination.
- Staff told us that if families had experienced bereavement, a member of staff from the reception team would call the bereaved, to offer condolences on behalf of the practice and advise them of support groups. The practice then sent a card with the practice leaflet which contained the contact details of local support groups.

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

- 85% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average and the national average of 86%.
- 82% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 83% and the national average of 82%.
- 89% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 88% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and improved services in response to those needs. For example, patients had access to online services such as booking appointments and repeat prescription requests. Staff at the practice had also met community leaders who represented ethnic minority groups who were registered at the practice. This was to share key health information messages and to ask what patients needed from the practice. This work was ongoing.
- The practice had established a multidisciplinary hub, which involved several clinicians working from the same room, who dealt with urgent and routine patient needs. Requests for home visits were triaged and if a home visit was needed, these were allocated to the most appropriate clinician. A review of home visit requests showed that following triage, 30% of requests did not need a home visit and 60% of those patients then came to the practice for their appointment; 40% had a telephone consultation. This enabled resources to be directed at those with urgent needs.
- The facilities and premises were appropriate for the services delivered. The practice made reasonable adjustments when people found it hard to access services. For example, patients with mobility needs and families were able to see their named GP in a downstairs room by request. The practice had a hearing aid loop. A self check in system was available in eight different languages.
- The practice had developed a patient information leaflet which detailed useful contacts and access to support. This was available to patients in the waiting area. A health resource file, which included a variety of information, for example local support services, had also been developed in four different languages, in response to patient's needs.

Older people:

- All these patients had a named GP.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- A GP undertook a weekly visit to five care homes where patients were registered at the practice.
- The practice reviewed any risks to existing family members of older patients who were admitted to hospital, and visited or referred them to support services as appropriate. This work was undertaken by clinicians in the multidisciplinary hub.

People with long-term conditions:

- Where patients had multiple long term conditions, their needs were reviewed in a coordinated way, where possible and consultation times were flexible to meet each patient's specific needs.
- Reviews were undertaken for those patients who lived in care homes. Patients with long term conditions were able to obtain an urgent appointment the same day.
- The practice liaised with the local district nursing team and community matron to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who did not attend for immunisations.
- All parents or guardians calling with concerns about a child under the age of 18 were offered an urgent appointment.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Two dedicated midwives held clinics at the practice two days a week and occasionally a third day, based on patients' needs.
- The practice had identified the need to offer contraceptive advice to women during the third trimester of their pregnancy for patients who were vulnerable to becoming pregnant and wished to avoid this. This work was in the process of being established in conjunction with the midwives.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The needs of these patients had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example advanced nurse practitioners were available during 7am to 8am for patients with long term conditions. Appointments with a GP were available until 7pm Monday to Friday.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice were proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Patients were able to book evening and weekend appointments with a GP through Suffolk GP+ (Suffolk GP+ is for patients who urgently need a doctor's appointment, or are not able to attend their usual GP practice on a weekday.)

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability or mental health needs.
- The practice offered longer appointments for patients with a learning disability. The practice informed vulnerable patients about how to access support groups and voluntary organisations.
- The practice had organised a health roadshow in 2016, where a number of different health, social and voluntary organisations attended, to give patients the opportunity to ask questions and seek advice. This was also open to patients from other practices to attend. They planned to hold a similar event once they had merged with another local practice.
- The practice were working with a local project, called the Julian project, which supported patients with complex social needs. They planned to have a link worker based at the practice so patients were able to have direct access to the service.

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

- Staff had a good understanding of how to support patients with mental health needs. There was a GP lead for mental health.
- The practice had a mental health link worker who was based in the practice once a week.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Reception staff at the practice were trained as dementia friends.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised. An emergency appointment clinic was held in the afternoon, with a GP and when these appointments had been filled, patients were triaged by clinicians in the multidisciplinary hub and an urgent appointment was made, if appropriate.
- The appointment system was easy to use. Patients were able to book appointments in person, by telephone or on line.

Results from the July 2017 national GP patient survey showed a mixed response in relation to patients' satisfaction with how they could access care and treatment. 243 surveys were sent out and 90 were returned. This was a 37% response rate and represented below 1% of the patient population. Two of the four patients we spoke with, and comments on one of the 19 completed comment cards showed dissatisfaction with the length of time to answer the telephone. All other responses were positive in relation to satisfaction levels for accessing care and treatment. Representatives from care homes were satisfied with how they could access care and treatment for registered patients.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the Clinical Commissioning Group (CCG) average of 79% and the national average of 76%.
- 59% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 79% and the national average of 71%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 90% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 88% and the national average of 84%.
- 89% of patients who responded said their last appointment was convenient compared with the CCG average of 87% and the national average of 81%.
- 78% of patients who responded described their experience of making an appointment as good compared with the CCG average of 79% and the national average of 73%.
- 77% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 69% and the national average of 58%.

The practice monitored patient feedback from the national GP patient survey and had completed their own patient survey which showed similar results. They had benchmarked their feedback with another local practice. Actions had been identified in response to the findings and lead staff members had been identified for each area. The practice had taken action in response to the patient feedback, for example, on ease of getting through by telephone. A new telephone system was in place, which gave access to 20 telephone lines and between 8am and 9am, six staff were responsible for answering the telephone. They planned that all staff members were responsible for answering the phone, unless they were in a patient consultation, to further improve the telephone answering response time.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do this. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 33 complaints were received from April 2016 to March 2017. We reviewed five complaints which had been received since December 2016 and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted on the results to improve the quality of care. For example, following a missed diagnosis, training was put into place and shared with all clinicians.

Are services well-led?

Good

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

Our findings

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

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. The practice were in the process of merging with another local practice.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and continued to address them. For example, the practice had employed an emergency care practitioner in 2014, to improve and develop the home visiting service. An audit of patients' requests for a home visit had been reviewed and an emergency care practitioner was employed due to their knowledge and established relationships with other organisations which could meet a range of patients' needs.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. One of the nurses was currently undertaking their training to become an advanced nurse practitioner.

Vision and strategy

The practice had a vision and credible strategy 'To deliver excellent clinical outcomes and safe, well led care to our population of patients and to be an effective first choice provider of that care.'

- There was a clear vision, mission statement and set of values. Their mission was to 'maximise patients' wellbeing by managing an innovative system of healthcare solutions through our team.' Objectives were in place and included for example, being patient centred, staff development and support and partner sustainability. These objectives formed part of the development plans for all staff.
- The practice had recently reviewed its statement of purpose, vision, mission statement, values and objectives. This was during a GP partner away day in November 2017, which concentrated on the merger with a local practice. Partners and staff at the other practice joined the away day. The practice informed us that they had held annual away days since 1993.
- The vision, values, mission statement and objectives were in line with health and social priorities across the region. Staff were aware of and understood and their role in achieving them.

Culture

The practice had a culture of delivering high-quality sustainable care, by managing an innovative system of healthcare solutions.

- The practice had developed services in line with their objectives. For example, the General Practitioner Personal Assistant team ensured continuity of care and follow up of patients, using trained non-clinical staff, with GP oversight. The multidisciplinary hub offered flexibility to meet the needs of patients, coordinate their care needs and develop staff through access to a dedicated GP partner who led and had oversight of this work. An audit on the effectiveness of the hub was completed in November 2015, which demonstrated positive outcomes. Patients who were at high risk were not delayed in needing to attend the accident and emergency department, as they had instant access to a GP for assessment and advice. Patients were subsequently followed up by a clinician in the hub. Six hours of GP training time was made available to supervise clinical and non-clinical practice staff. Primary care associates received training and mentoring in real time without affecting or compromising patient access.
- Staff stated they felt supported and valued and proud to work in the practice.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values. We saw examples of non-clinical audits which had been introduced to ensure that safe and effective care was being provided and that improvements identified were acted upon.

Are services well-led?

Good

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

- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. Clinical staff were valued members of the practice team and were supported to meet the requirements of professional revalidation, where necessary.
- There was a strong emphasis on the safety, well-being and work life balance of all staff.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships and joint working arrangements promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities, which included staff in lead roles. Staff we spoke with were aware of those with lead roles.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. The practice had developed a booklet which summarised the main points of frequently used policies. Staff we spoke with reported that they found these useful.
- A number of meetings were held at the practice which included, for example, the practice team, clinical staff, senior management and nursing team meetings. Staff confirmed that these were held regularly and the minutes we saw were detailed.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks, which included risks to patient safety.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.
- The management team monitored workload and capacity to ensure that outcomes for patients were planned for and achieved. This included, for example, a monthly review of the uptake of learning disability health checks, cervical screening and the Quality and Outcomes Framework (QOF) achievement. The practice were aware of their lower than average achievement for cervical screening and were taking action to improve this.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through clinical audits and review of their work. Practice leaders had oversight of Medicines and Healthcare Products Regulatory Agency (MHRA) alerts, incidents and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns, improve quality and improve patient satisfaction.
- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- The practice monitored performance information and management and staff were held to account. For example, the practice manager monitored the appointment availability, uptake and 'did not attend' rates to identify opportunities for work to be completed by staff with identified time.
- The practice submitted data or notifications to external organisations as required.

Are services well-led?

Good

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

- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A range of patient, staff and external partners' views and concerns were encouraged, heard and acted on. For example, the practice had changed the phone system to have 20 lines coming in in response to feedback from patients about the difficulty in getting through to the practice by telephone.
- The practice had identified some patients to be part of the patient participation group and were continuing work to identify patient representatives from the minority ethnic groups to ensure the views of these patients were obtained. They had decided to wait until the merger with another local practice had been completed so that there would be one patient participation group. The practice planned to have a core group who met four times a year and a virtual group with two way communications to share ideas and suggestions.
- The practice had developed a staff newsletter to share key information about the practice and the staff with the staff team. The first issue was shared in December 2017. This was felt to be particularly important with the planned merger with another local practice. The practice planned to have quarterly staff newsletters.
- Staff were encouraged to raise concerns and share ideas to improve the practice. Staff gave examples of how their suggestions had been implemented by the practice.For example, one of the advanced nurse practitioners developed a pathway for checking for blood in patient's urine at chronic disease management clinics. An audit was undertaken after one year and found that this had led to the diagnosis of important pathology in six patients.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning and continuous improvement.

- There was a strong focus on continuous learning, improvement and innovation at all levels within the practice.
- Leaders and managers encouraged staff to take time out to review individual objectives, processes and performance.
- The practice made use of internal and external reviews. Learning was shared and used to make improvements.

The practice was a teaching practice for medical students and a training practice for qualified doctors training to become GPs. The practice offered opportunities for A level students who had been unsuccessful in their medical school application, to work as a healthcare assistant for one year. The practice advised that of the seven staff who have undertaken this opportunity, all of them have since gained entry to medical school.