Little St John Street 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?	Requires improvement
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

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 6

What people who use the service say 9

Areas for improvement 9

Detailed findings from this inspection

Our inspection team 10

Background to Little St John Street Surgery 10

Why we carried out this inspection 10

How we carried out this inspection 10

Detailed findings 12

Action we have told the provider to take 26

Overall summary

Letter from the Chief Inspector of General Practice

We visited Little St John Street Surgery on the 25 February 2015 and carried out a comprehensive inspection.

The overall rating for this practice is good. We found that the practice provided an effective, caring, responsive and well led service. Improvements were needed to ensure that the dispensary operated in a safe way.

We examined patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups.

Our key findings were as follows:

- The practice was friendly, caring and responsive. It addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care.
- Patients were satisfied with the appointment system and felt they were treated with dignity, care and respect. They were involved in decisions about their care and treatment and were highly complementary with the clinical care that they received from the practice.
- The needs of the practice population were understood and services were offered to meet these. Feedback from the care homes where patients were registered with the practice was very positive.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.
- There was scope to improve arrangements to ensure patient safety was maintained in relation to the safe management of medicines.

Summary of findings

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

- Improve arrangements for the safe management of medicines. The provider did not have appropriate arrangements in place for the dispensing of medicines. Medicines were sometimes dispensed by one dispenser to patients without checks by other suitably qualified members of staff. Dispensing staff had not all attained suitable qualifications.

In addition the provider should:

- Improve the security of the dispensary to reduce the risk of unauthorised access. This includes unauthorised access to prescription pads.
- Have documented records for the checking of the stock of controlled drugs and expired medicines.
- There was scope to further embed learning from significant events, by including dispensing errors and through more effective sharing of learning following investigations.
- There was scope to improve the process for ensuring that actions had been undertaken following receipt of safety alerts.
- Ensure all staff complete training which is deemed mandatory by the provider to their role and ensure all staff receive an annual appraisal.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. The practice did not have appropriate arrangements in place for the dispensing of medicines. At times, medicines were dispensed by one dispenser and were not always checked before being handed to patients. Dispensing staff were not all qualified. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses although there was scope to improve this within the dispensary. Lessons were learned from significant incidents and complaints and communicated to support improvement, although more effective documentation would ensure this process was more robust. Risks to patients who used services were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. We saw evidence of effective multidisciplinary working.

Staff had received training appropriate to their roles and further training needs had been identified and planned for. Not all staff had received an annual appraisal but the practice were aware of this and had a plan in place to address this.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with NHS England and the Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice with urgent appointments available the same

Summary of findings

day. The practice operated a full service on Saturday morning. The practice had good facilities and used their limited space effectively. They were well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice recently formalised their vision and this was due to be shared with staff. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place. The practice were in the process of updating their policies and making them all available to staff electronically. The practice were introducing a system which recorded when policies had been read by staff as part of its governance process. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). The clinical leadership at the practice was positive and staff told us they felt supported.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. The practice offered nurse led clinic appointments for a number of long term conditions, including asthma and diabetes. A diabetes specialist nurse attended the practice on a monthly basis to undertake a joint clinic with the diabetes lead. All patients with long term conditions had structured reviews, at least annually, to check their health and medication needs were being met. For those people with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. A midwife led clinic was available for patients on a weekly basis. A recall system was in place for the mother and baby six week check. The practice completed preschool checks for all children registered at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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. Early morning appointments were available on three week day mornings and a full service was provided to patients on Saturdays mornings. The practice offered telephone consultations as well as a full range of health promotion and screening which reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed above the Clinical Commissioning Group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability and 49% had received an annual health check. There was a process for following up vulnerable patients who did not attend for their appointment. We were told that longer appointments were given to patients who needed more time to communicate during a consultation, for example people who needed an interpreter. There were arrangements for supporting patients whose first language was not English.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice scored above the Clinical Commissioning Group (CCG) and England average for people with mental health needs, including those with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health

Summary of findings

including those with dementia. The practice had in place advance care planning for patients with dementia. We saw evidence of effective monitoring of patients who were prescribed methadone. A mental health link worker attended the practice every week.	

Summary of findings

What people who use the service say

We spoke with 16 patients during our inspection. All of the patients told us that they were able to get an appointment easily and felt that they had sufficient time with the GP and were not rushed during their consultation. They also reported a good experience with getting repeat prescriptions. None of the patients we spoke with had any concerns about the practice.

We collected 35 Care Quality Commission comment cards from a box left in the practice two weeks before our inspection. The majority of the comments on the cards were positive about the practice. Patients reported that all the staff were friendly and helpful and they were particularly satisfied with the quality of the clinical care that they received from the practice. We received a number of positive comments about the cleanliness and standards of hygiene at the practice. The majority of patients also reported that they were able to get an appointment easily, although one patient found booking an appointment could be difficult.

We spoke with representatives from three care homes where patients were registered with the practice, all of whom were very complimentary about the service provided by the GPs and the speed of attendance. We were told that one named GP undertook a weekly planned visit to patients and if a patient needed to see a GP before the planned visit, then a home visit would be undertaken, usually by the named GP. Patients with long term conditions were reviewed in their home every six months by the named GP and patients prescribed medicines were reviewed regularly.

Areas for improvement

Action the service MUST take to improve

- Improve arrangements for the safe management of medicines. The provider did not have appropriate arrangements in place for the dispensing of medicines. Medicines were dispensed by one dispenser and were not checked by another dispenser. Dispensing staff were not all qualified.

Action the service SHOULD take to improve

- Improve the security of the dispensary to reduce the risk of unauthorised access. This includes unauthorised access to prescription pads.
- Have documented records for the checking of the stock of controlled drugs and expired medicines.
- There was scope to further embed learning from significant events, by including dispensing errors and through more effective sharing of learning following investigations.
- There was scope to improve the process for ensuring that actions had been undertaken following receipt of safety alerts.
- Ensure all staff complete training which is deemed mandatory by the provider to their role and ensure all staff receive an annual appraisal.

Little St John Street Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP Specialist Advisor. The team also included a CQC National Advisor, a practice manager specialist advisor and a medicine management inspector.

Background to Little St John Street Surgery

Little St John Street Surgery, in the Ipswich and East Suffolk Clinical Commissioning Group (CCG) area, provides a range of primary medical services to approximately 6450 registered patients living in Woodbridge and the surrounding villages.

There are two GP partners who hold financial and managerial responsibility for the practice. There are three salaried GPs, three practice nurses and a health care assistant. There are also receptionists, administration, secretarial staff and a practice manager. The practice has a dispensary, which is led by a dispensary manager and dispensing staff.

According to Public Health England information, when compared to the practice average across England, Little St John Street Surgery has a slightly lower proportion of patients under 18. It has a significantly higher proportion of patients aged over 65 and 75 and a slightly higher number of patients aged over 85. Income deprivation affecting children and older people is significantly lower than the practice average across England.

Why we carried out this inspection

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

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

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

How we carried out this inspection

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

Detailed findings

We carried out an announced visit on 25 February 2015. During our visit we spoke with a range of staff, including four GPs, two nurses, a health care assistant, dispensary, reception and administration staff and the practice manager.

We spoke with one member of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care. We also spoke with 16 patients who used the practice. We reviewed 35 comments cards where patients had shared their views and experiences of the practice. We spoke with representatives from three residential homes where patients were registered with the practice.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

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, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists, administrators and nursing staff were aware of the system for raising significant events and felt encouraged to do so. We looked at the records of significant events and saw these had been completed in a comprehensive and timely manner. We looked at three significant event analyses and saw evidence of action taken as a result. One significant event related to the monitoring of lithium carbonate and resulted in a protocol change, requiring patients prescribed this medication to have their own monitoring book. (Lithium carbonate is used to treat a number of mental health problems that are thought to be due to a chemical imbalance in the brain.) There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. However, there was scope to improve the documentation of the investigation and to broaden learning from significant events.

We saw that significant events were discussed at monthly clinical meetings. However, when we looked at records of dispensing errors we noted they had not been raised as significant events at the meetings so that they could be discussed and where appropriate, necessary actions taken. By talking to staff we established that few near-miss dispensing errors had been recorded so trends of these errors could not be identified and monitored.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the monthly clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. There was scope to improve the process for ensuring that actions had been undertaken following receipt of safety alerts.

Reliable safety systems and processes including safeguarding

The practice had a range of documentation to advise staff of their role and responsibility in relation to safeguarding children and vulnerable adults. This included safeguarding adults and safeguarding children policies, contact information for safeguarding professionals external to the practice and flow charts for making a safeguarding referral. We looked at training records which showed that the majority of staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their safeguarding knowledge. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also 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 out of normal hours. Contact details were easily accessible to staff at the practice.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plan.

There was a chaperone policy, and notices advising patients of this service were visible in the waiting room noticeboard and in consulting rooms. (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). Staff told us that both clinical and non-clinical acted as chaperones. We found that not all chaperones had received formal training. However, their

role had been discussed at a staff meeting. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Not all staff who acted as chaperones had a Disclosure and Barring Service (DBS) check. We spoke with the practice about this. They advised they would stop using chaperones who did not have a DBS check and would complete a risk assessment on all staff before they can act as a chaperone.

Medicines management

We noted the arrangements in place for patients to order repeat prescriptions. Patients we spoke with and their representatives told us they received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. The practice had extended dispensing hours on Saturday mornings.

Prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were tracked through the practice in accordance with national guidance. We looked at the arrangements for the storage and security of prescription forms and medicines at the practice. Improvements were needed to ensure they could only be accessed by authorised members of staff.

We noted that the dispensary was small and would benefit from a larger work area. Medicines awaiting collection were stored in the reception area and handed to patients by receptionist staff and not the dispensers. This reduced the potential for patients to discuss their medicines with dispensary staff. Staff told us that they also experienced difficulties ensuring patient confidentiality when counselling patients about their medicines.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. There were arrangements in place for the destruction of controlled drugs. We checked a sample of controlled drugs and found we could account for them in line with registered records. We were told that staff undertook regular audits of controlled drugs but there were no records about this. Staff we spoke with were unaware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Processes were in place to check medicines in the dispensary and doctor's bags and we found these were within their expiry date and suitable for use. The Practice manager later informed us the most recent check of doctor's bag was undertaken on the 16 January 2015. However, records were not available to demonstrate the checks had been completed. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. Dispensary staffing levels were overall in line with DSQS guidance. However, we were told that at times, a single-handed dispenser routinely supplied medicines to patients without checks by other suitably qualified members of staff. Therefore, we could not be assured that safe procedures for medicine supply were always being followed. Medicines awaiting collection were routinely handed out by receptionists who had not received relevant training. Medicines awaiting collection were routinely handed out by receptionists who had not received relevant training. In addition, although two of the three regular members of dispensary staff were working towards attaining a suitable qualification, at the time of our inspection staff confirmed that they had not yet attained a suitable dispensing qualification. We were unable to establish from records that the competence of two of the members of dispensing staff had been checked recently. Therefore we could not be assured that patients were provided their medicines by staff who had attained dispensing qualifications and were regularly confirmed as competent. Subsequent to the inspection, we were informed by the provider on the 12 May, that the three dispensing staff had now had their competency checked.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The cleaning of the practice was undertaken by an external cleaning company. We were told by the practice manager that cleaning schedules were place and that monthly checks of the cleaning were undertaken by the practice manager and the cleaning company manager.

The practice had a lead nurse responsible for infection control. We were advised by the practice manager that the

lead for infection control was booked to undertake further infection control training in May. The majority of staff had received infection control training. The most recent infection control audit was completed in September 2013. There was an infection control meeting held quarterly. We looked at minutes of these meetings which showed that improvements in relation to infection control were undertaken.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment 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 also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy 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. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment which included weighing scales and blood pressure measuring devices.

Staffing and recruitment

The practice had a number of policies that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment . For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, staffing and dealing with emergencies and equipment. The practice also had a health and safety policy and there was an identified health and safety lead. We saw that any risks, including risks to patients, significant events, complaints or infection control were discussed at the monthly clinical meetings. These were also discussed at the business meetings which were held between the practice manager and the two GP partners every two weeks and also on an informal basis, as needed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that the majority of staff had received training in basic life support and a date had been booked for the three new staff members to receive this training. 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 monthly.

Emergency medicines were available in a secure area of the practice and included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Staff we spoke with knew of their location. Processes were also in place to check whether emergency medicines were available and within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

Requires improvement

Are services safe?

A disaster recovery plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of building, power failure, loss of medical records, incapacity of GPs and loss of the telephone system. The document also contained relevant contact details for staff to refer to. Copies of the disaster recovery plan were kept off site.

The practice had a fire safety policy and had carried out a fire risk assessment that included actions required to maintain fire safety. We saw records of regular checks of the fire alarm. We saw evidence of a recent fire drill, which had been successful and learning points had been identified and actions taken to ensure these were shared with practice staff. Records showed that over half of the staff were up to date with fire training.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The GPs told us they lead in specialist clinical areas such as diabetes, coronary heart disease, dermatology and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Patients told us that they were reviewed regularly for their long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened.

National data showed that the practice was in line with referral rates to secondary and other community care services. All GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made and that improvements to practice were shared with all clinical staff. The practice made effective use of the specialist knowledge and expertise of the GPs at the practice. For example, referrals were made to one of the GPs who specialises in dermatology. There was evidence that this had reduced the number of referrals which had been made to secondary care services and had resulted in patients being seen more locally.

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.

Management, monitoring and improving outcomes for people

There was evidence of effective structuring of patient records which was undertaken by clinicians. This included the use of comprehensive templates which had been devised by the practice. This ensured that care and treatment provided was comprehensive, standardised and took into account best practice guidance.

The practice showed us seven clinical audits that had been undertaken. Two of these were completed audits where the practice was able to demonstrate the improved outcomes for patients. For example, the practice increased the number of vulnerable patients with special patient notes from 30% to 98% when the clinical audit cycle was repeated. Another clinical audit related to improved monitoring and communication between clinicians of patients who were prescribed lithium carbonate. (Lithium carbonate is used to treat a number of mental health problems that are thought to be due to a chemical imbalance in the brain.)

GPs in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and National Institute for Health and Care Excellence (NICE) guidance. We found that GPs who undertook minor surgical procedures were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning.

The practice were part of the Deben Health local commissioning group, a group of six GP practices in Suffolk. One of the initiatives Deben Health Group had set up was 'super multi-disciplinary team' meetings which were held every two to three months. We were told that each practice identifies two complex patients to be reviewed at the meeting. This meeting was also attended by a Consultant Geriatrician. The GPs told us that this provided useful external peer review of the management of patients with complex needs.

The practice also used the information they collected for the Quality and Outcomes Framework (QOF) and their

Good

Are services effective?

(for example, treatment is effective)

performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (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 e.g. diabetes and implementing preventative measures. The results are published annually.

The QOF data showed that the practice had a higher prevalence of many clinical conditions, including for example, asthma, cancer and dementia than the CCG and England average. The practice scored higher than the CCG and England average for the way it treated the majority of these conditions.

There was a protocol for repeat prescribing which was in line with national guidance. We saw evidence that patients had received a timely medication review, which was face to face. We saw evidence of effective monitoring of patients who were prescribed methadone. The patients we spoke with confirmed that their medicines were reviewed regularly. This was also confirmed by the representatives we spoke with from the care homes where patients were registered with the practice.

Effective staffing

All new staff underwent a period of induction at the practice. We saw documented evidence that an induction checklist had been completed for recent new starters. However these had not all been signed by the staff involved confirming the information had been understood and tasks completed satisfactorily. The staff we spoke with confirmed that they had received an induction when they started work at the practice.

The practice staff included medical, nursing, dispensary, managerial and administrative staff. We reviewed four staff files and saw that most staff were up to date with attending training deemed mandatory by the practice, such as basic life support, safeguarding and health and safety. The practice were in the process of setting up a system where they could more easily identify which staff were out of date with their mandatory training so that they could forward plan to ensure that this was completed by all staff. We saw evidence that this work had been started.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and 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).

The practice had an appraisal policy and process in place. However, we found only some of the staff we spoke with had received an appraisal in the preceding 12 months and the records we viewed confirmed this. The practice manager told us that not all staff had received an appraisal in the previous 12 months but dates had been set to conduct the outstanding appraisals.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and ear syringing. Those with extended roles, for example monitoring patents with long term conditions such as diabetes, were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of 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 had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) The GP contacted each patient within two days of them being discharged from hospital in order to follow up on their care and treatment. We saw that the process in place for responding to hospital communications was working well in this respect.

Good

Are services effective?

(for example, treatment is effective)

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and an age concern representative and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. These meetings were attended by the hospice nurse, district nurses and the GPs.

Patients had access to a mental health link worker who visited the practice on a weekly basis. The practice worked closely with this worker and was able to access them easily through using the shared computer system. The practice also provided an extended diabetes service, as a diabetes specialist nurse supported the diabetes lead on a monthly basis to review patients with more complex diabetes needs.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice used the Choose and Book system for making referrals. (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). The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment. We noted that the extensive use of clinical templates resulted in efficient clinical care and rapid production of concise referral letters. Referral letters included information about the patient's previous three consultations at the practice.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary, for example when patients needed minor surgery. We looked at records which confirmed that written consent had been obtained. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with, and received comments from, confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. The practice nurse confirmed consent was always obtained from parents prior to immunisations being given. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.)

We found that the majority of clinical staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The practice had Mental Capacity Act guidance available for staff. The majority of 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. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

All staff were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate. This was supported by the patients we spoke with during the inspection and from the feedback from the representatives of patients who lived in care homes.

Health promotion and prevention

There was a large range of up to date health promotion information available at the practice and on the practice website, with information to promote good physical and

Good

Are services effective?

(for example, treatment is effective)

mental health and lifestyle choices. The practice website referred patients to a range of information supplied by NHS Choices. This included information on children's health, women's health, men's health, sexual health, healthy living and vaccinations.

We saw that new patients were invited into the surgery when they registered, to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a nurse or a health care assistant. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner. The practice offered NHS Health Checks to all its patients aged 40-75 and these were undertaken by a nurse or health care assistant.

The practice had numerous ways of identifying patients who needed additional support. The practice kept a register of all patients with a learning disability and offered them an annual health check. On the day of our inspection, we were told that 16 of the 33 patients with a learning disability (49%) had attended for an annual health check. There was a process in place for following up those who did not attend.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored higher than the Clinical Commissioning Group (CCG) and England average for cervical cytology, primary prevention of cardiovascular disease and child health surveillance. Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Clinical staff we spoke with told us about the arrangement in place for following up patients who did not attend for their immunisations.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a person centred culture and staff and management were committed to working in partnership with patients. During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with 16 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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. The waiting room was located near to reception but had a glass door to maintain privacy of patients at the reception desk, whilst ensuring that patients could be observed for signs of deteriorating health. There was not a lot of space at the practice, which included the reception area. There was a notice informing patients that if they wanted to speak in private they could. However, we were told that this was not always possible as often rooms were in use.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (81%) and for whether nurses listened to them, 80% reported this as being good. These results were below average when compared with other practices in the CCG area. Satisfaction rates for patients who thought they were treated with care and concern by their GP was 91% and for whether the GP listened to them, 93% reported this as being good. 95% of respondents described their overall experience of the practice as good and 88% of patients stated they would recommend the practice. These results were above average when compared with other practices in the CCG area.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive and did not feel rushed. Patient feedback on the comment cards we received was also positive and aligned with these views.

Data from the national GP patient survey, published on 8 January 2015, showed 86% of practice respondents said the GP involved them in care decisions, 93% felt the GP was good at explaining tests and treatments and 96% said the GP was good at giving them time. These results were above average when compared with other practices in the Clinical Commissioning Group (CCG) area. In relation to nurses: 66% said they involved them in care decisions; 79% felt they were good at explaining tests and treatments and 82% said they were good at giving them enough time. These results were below average when compared with other practices in the CCG area.

Patient/carer support to cope emotionally with care and treatment

Information for carers, in the form of leaflets and posters were displayed in the waiting room, on the waiting room TV screen and on the practice website. These provided information on a number of support groups and organisations that could be accessed for patients, relatives and carers. When a new patient registered at the practice they were asked if they were a carer and offered appropriate support. The practice identified patients who

Good

Are services caring?

were also carers on the computer system so staff and clinicians were automatically alerted to patients who were also carers. This ensured that the practice staff were aware of the wider context of the patients' health needs.

Staff at the practice offered emotional and practical support for those who had recently suffered a bereavement. Staff told us that if families had suffered a bereavement, their usual GP contacted them. Staff told us families who had suffered bereavement were identified and the electronic records system was updated to inform all staff at the practice. This helped to ensure that when a bereaved patient attended the practice, staff were able to respond appropriately. In addition to the support provided by the practice staff, we were told that patients were referred to local external organisations that provided specialist services. Patients we spoke with who had had a bereavement confirmed they had received support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs.

There had been very little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for people who needed them, which included patients with long term conditions. Home visits were available to patients who needed a home visit. One named GP was responsible for approximately 80 patients who lived in five local care homes. They visited on a specific day each week. The GP had remote access to the patients' medical records so that they could be accessed and updated on site. Care plans were in place for these patients which were regularly updated. They also supported the training of nursing staff in the care homes to improve care and treatment for patients.

The practice had an active Patient Participation Group (PPG) and had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the PPG. (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) We reviewed the patient survey, which was undertaken in 2014. We found that the views of patients had been listened to and improvements had been made in response to patients' views. These included improvements to ensure up to date and the most relevant health information was communicated to patients, a new screen call system installed in the waiting area and actively promoting other methods to obtain patient feedback, for example a suggestions box in the waiting area.

Patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this.

Tackling inequity and promoting equality

The practice had an equality and diversity policy and provided equality and diversity training, which the majority of staff had completed. The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. Patients who were hard of hearing were able to access the service using a hearing loop. Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Longer appointments were also available for patients who needed them. There was a process in place for following up vulnerable people who had not attended for their appointment and for those who had not responded to an invitation letter for an appointment at the practice. Depending on the circumstances, we were told that the patients would be sent another letter reminding them of their appointment or the GP would be informed and would decide whether to contact the patients by telephone.

The practice was situated in a single level building. There was a ramp to the practice and handrails to support independent access to those patients with mobility needs and those who used prams. The waiting area was large enough to accommodate patients with wheelchairs and prams. There was not easy access for people with mobility needs, to all the treatment and consultation rooms. The practice were aware of the needs of their patients and we were told that they provided appropriate support to people to enable them to access the practice. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice were aware that their premises were limited with space and had plans which they hoped would address this.

Access to the service

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments, telephone consultations and home visits. Appointments could be booked by telephone, in person, online or via an automated telephone system. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, they were automatically transferred to the out of hour's service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice opened every week day from 8.00am until 6.30pm and every Saturday between 8.30am and 11.30 am. The same service was available on Saturdays as it was on weekdays. Early morning appointments were available from 8.10am on Tuesdays, Wednesdays and Thursdays. This was particularly useful to patients with work commitments.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015 and found that 86% of patients described their experience of making an appointment as good and 99% said the last appointment they got was convenient. These results were higher when compared to other practices in the Clinical Commissioning Group.

Comments received from patients on the day of the inspection showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. They confirmed that they could see another doctor if there was a wait to see the doctor of their choice. The majority of the comments cards gave positive feedback on the appointments system.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. There was information on making a complaint in the practice patient information leaflet, on the practice website and information was on display at the practice. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint but they believed that any complaint would be taken seriously.

We looked at three complaints received in the last twelve months. These had been acknowledged, investigated and a response had been sent to the complainant. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate.

The practice discussed and reviewed complaints at the monthly clinical meetings in order to identify areas for improvement and share learning. For example, improving communication with patients.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to 'provide high quality medical services efficiently and safely to all our patients, with the co-operation and teamwork of all members of the primary care team'. The mission of the practice was 'To achieve our vision by offering the highest standards of care to all registered and temporary patients and to listen to their views and needs. And to ensure that all staff employed by the practice are trained and competent to guarantee the smooth running of the practice for the benefit of all users.'

They had an up to date statement of purpose that described their objectives, vision and strategy. Staff spoken told us they felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Some of these were available to staff on the desktop on any computer within the practice. Some policies were displayed in the practice and there were separate folders which contained policies which related to a specific area, for example safeguarding. Staff we spoke with knew where to find these policies if required. We looked at a sample of these policies and procedures and most had been reviewed and were up to date. There was a process in place for policies to be reviewed and agreed before being implemented. We were told by the practice manager that they were in the process of reviewing a number of policies in order to get them uploaded so that they could all be accessed electronically.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, one of the GP partners was the lead for safeguarding and the practice manager was the lead for health and safety. We spoke with eleven 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. The QOF data for this practice showed it was performing in line with or above national standards. The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. Any risks identified were discussed both informally with the two GP partners and formally at the partners meeting, which was usually held every week. These were also discussed at the doctors meeting, held every two weeks and the monthly clinical meeting.

The practice were in the process of setting up a system where they could more easily identify which staff were overdue with their mandatory training so that they could forward plan to ensure that this was completed by all staff.

Leadership, openness and transparency

There were a number of staff meetings held at the practice. These included monthly clinical meetings, doctors meetings every two weeks, reception meetings on an ad-hoc basis, monthly dispensary meetings and practice team meetings which were held on a quarterly basis. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues, either with the practice manager, the GPs or at the meetings they attended. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was low turnover of staff.

Seeking and acting on feedback from patients, public and staff

We found the practice listened and responded in a timely way to formal and informal feedback from patients. Feedback from patients had been obtained through patient surveys, a suggestions box in the waiting room and complaints. The practice had monitored and assessed some aspects of the quality of its dispensing service but planned to undertake more comprehensive assessments.

The practice had an active patient participation group (PPG). (PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.) A representative of the PPG told us

Are services well-led?

Good

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

they were able to help inform and shape the management of the practice in relation to patient priorities, any planned practice changes and the outcomes from local and national GP surveys.

The staff we spoke with described the working environment as caring and supportive and that they felt valued. We were told they felt that any suggestions they had for improving the service would be taken seriously and would be listened to. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in paper copy and electronically on any computer within the practice. Staff we spoke with were aware of the whistleblowing policy. Staff we spoke with felt that they were easily able to raise any concerns and that they would be listened to.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They commented positively on the clinical support they could easily obtain from the GPs. We were told that staff regularly attended local peer support meetings, which included practice manager meetings and diabetes meetings. The practice also closed for staff training for half a day a month, for nine months of the year.

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. There was scope to improve this in relation to incidents within the dispensary. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. Complete audit cycles showed that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment. The results of patient surveys were also used to improve the quality of services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patients were not protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the dispensing of medicines. Medicines were sometimes dispensed by one dispenser to patients without checks by other suitably qualified members of staff. Dispensing staff had not all attained suitable qualifications. Regulation 12 (1) (2) (c) (g).