Woodcock 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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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Woodcock Road Surgery on 24 September 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed, and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity, and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice was safe and is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and report significant events or other incidents. Lessons were learnt and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed and there were effective arrangements to identify and respond to potential abuse. Medicines were managed safely and the practice was clean and hygienic. Staff were recruited through processes designed to ensure patients were safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity, and respect and they were involved in care and treatment decisions. We also saw that staff treated patients with kindness and respect and in a way that was individual to those patients that needed extra support. Confidentiality was maintained and information was available to patients in formats that they could understand. The practice demonstrated that they prioritised patient centred care.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to

Summary of findings

complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on and the patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice had worked closely to recover and recycle equipment and resources from a locally closed health facility, in order to upgrade and improve the practice equipment and facilities and save NHS money.

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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. A hearing loop was available for patients who had hearing impairments. The practice facilitated the attendance of the 'Deaf Association van'; this provided hearing aid servicing and repairs for patients. In addition the practice acted as a recognised centre for the replacement of hearing aid batteries throughout the year.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients were encouraged to attend the practice and to use the practice self-monitoring blood pressure machine, a protocol was followed by staff to ensure the GPs were aware of the patient's latest readings and patients were updated at their next review.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were comparable with local and national averages for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. On the day telephone appointments were available and patients could specify when they would be available to speak with the GP. For example outside of school hours or during a coffee or lunch break. The premises were

suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Antenatal care was referred in a timely way to external healthcare professionals. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered extended opening hours on Thursdays between 6.30pm and 8.30pm as well as daily telephone consultations. This benefitted patients who were unable to attend the practice during working hours. The practice provided general health advice including a monthly sexual health clinic to young people. In addition appointments were available to young people registered with the practice where they could receive health advice or treatment including sexual health services. The practice had recently introduced electronic prescribing (ETP2); this enabled the practice to send patients repeat prescription directly to a pharmacy of the patients' choice. There were also systems in place to arrange for patients prescriptions to be delivered to a preferable location, for example a patients workplace.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was accessible for any vulnerable group. The practice had identified patients with learning disabilities and treated them appropriately. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation. The clinicians provided patients with referral to a health trainer, who attended the practice weekly to support patients in improving their mobility, manage body weight and maintain a healthy lifestyle. The practice offered telephone consultations and contact via email. There was a booking in touch screen in the reception area with a variety of languages for people whose first language was not English. The practice ensured translators attended the practice to provide a confidential translation service to people whose first language was not English. A hearing loop was available for patients who had hearing impairments. The practice facilitated

the attendance of the 'Deaf Association van'; this provided hearing aid servicing and repairs for patients. In addition the practice acted as a recognised centre for the replacement of hearing aid batteries throughout the year.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health. The practice was aware of the number of patients they had registered who had dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations and referred to other professionals for counselling and support according to their level of need. One GP worked with a local project to provide telephone support to Paramedics on 999 calls, (this support covered complex issues such as assessing the mental capacity of a patient who may decline admission to hospital) resulting in an 85% reduction in admissions to a local hospital.

Summary of findings

What people who use the service say

The national GP patient survey results published on July 2015 showed the practice was performing broadly in line with local and national averages. There were 121 responses which represented a response rate of 36%.

- 65% find it easy to get through to this surgery by phone compared with a CCG and national average of 73%.
- 83% find the receptionists at this surgery helpful compared with a CCG and national average of 87%.
- 62% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 61% and a national average of 60%.
- 85% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 87% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 74% describe their experience of making an appointment as good compared with a CCG average of 74% and a national average of 73%.
- 63% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG and national average of 65%.
- 60% feel they don't normally have to wait too long to be seen compared with a CCG and national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 15 comment cards which were all positive about the standard of care received. These findings were also reflected during our conversations with patients during and after our inspection. We spoke with four patients during our inspection and three representatives of the patient participation group. The feedback from patients was extremely positive. Patients told us they were able to speak to or see a GP on the day and where necessary get an appointment when it was convenient for them with the GP of their choice. We were given clear examples of effective communication between the practice and other services. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing, reception and the management teams were all very approachable and supportive. We were told they felt confident in their care and liked the continuity of care they received at the practice. The patients we spoke with told us they felt their treatment was professional and effective and they were very happy with the service provided.

Woodcock Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Woodcock Road Surgery

Woodcock Road Surgery provides general medical services to approximately 7500 patients in the Mile Cross, Catton and Hellesdon areas of Norwich. Woodcock Road surgery has been a GP surgery since the 1960s and since that time has undergone some extensive development and redesign. The practice is in the process of further development to include another treatment room. All treatment and consultation rooms are situated at ground level. Parking is available with level access and automatic doors. The practice had recently been accredited as a training practice and was anticipating accepting medical students in the future.

The practice has a team of five GPs meeting patients' needs. Four GPs are partners, meaning they hold managerial and financial responsibility for the practice. There is a team of three practice nurses, a health care assistant, a phlebotomist and a health support worker who run a variety of appointments for long term conditions, minor illness and family health.

There is a practice manager, an office manager, an IT administrator and a team of non-clinical administrative, secretarial and reception staff who share a range of roles, some of whom are employed on flexible working arrangements. Community midwives run sessions twice weekly at the practice.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8.30am and 6pm, Monday to Friday. Appointments are from 8.30am to 11.30am with GPs and 8.30am to 12am with nurses every morning. Weekly afternoon appointments are available from 3pm to 5.30pm daily. Extended hours appointments are available form 6.30pm to 8.30pm Thursday evenings. In addition to pre-bookable appointments which can be booked up to six weeks in advance, urgent appointments are also available for people that needed them.

Outside of these hours, medical care is provided by Integrated Care 24 Limited (IC24). Primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services 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.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

The inspection team :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC's intelligent monitoring systems.
- Carried out an announced inspection visit on 24 September 2015.
- Spoke with staff and patients.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All relevant incidents and complaints received by the practice were entered onto the system and automatically treated as a significant event. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings including quarterly clinical governance meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. We saw that 'event sheets' which detailed any changes made and lesson learnt were provided for all staff. Recent examples included a review of prescribing errors, and a review of emergency medicines retained by the practice.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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).
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella (a germ found in the environment which can contaminate water systems in buildings).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The practice had recently achieved a rating of the third lowest prescribing practice in the CCG, despite high prevalence's of young patients and a high level of deprivation locally. Prescription pads were securely stored and there were systems in place to monitor their use. The practice had recently introduced electronic prescribing (ETP2); this enabled the practice to send patients repeat prescription directly to a pharmacy of the patients' choice. Making the

Good

Are services safe?

prescribing of medicines safer, more efficient and convenient for patients and staff. Information about this was available to patients at reception, in the practice leaflet and on their website.

- Recruitment checks were carried out. 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). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.
- Arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs were in place. We saw there was a rota system for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to 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.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The document was kept under review and copies were located both on and off-site. The document also contained relevant contact details for staff to refer to and external organisations that would be able to provide the necessary support required to maintain some level of service for their patients.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards. This included National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. 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. The practice used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. 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.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 83.8% of the total number of points available, with 9.8% exception reporting. This practice was not an outlier for any QOF clinical targets. Data from 2013/2014 showed;

- Performance for diabetes related indicators was worse than the CCG and national average. With the practice achieving 75.9%, this was 10.5 percentage points below the CCG average and 14.6 percentage points below the national average.
- Performance for asthma, cancer, hypothyroidism, learning disabilities and palliative care were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- Performance for mental health and hypertension related indicators was worse in comparison to the CCG and national average with the practice achieving 75.3%; this was 11.5% below the CCG average and 15.1% below the national average for mental health indicators. The practice achieved 80.2% for hypertension; this was 21.3% below the CCG average and 28.2% below the national average.
- The dementia diagnosis rate was below the national average.

We noted some QOF indicators were lower for certain disease areas, there was a lower than anticipated achievement for recording alcohol consumption in patients on the Mental Health register and the practice had achieved lower blood pressure targets in patients with diabetes. We discussed these indicators with the GPs. The practice recognised the relatively high levels of deprivation of the practice population in comparison to the local CCG and a high patient turnover. In addition, the practice had in the past experienced difficulties in encouraging patients to attend for health and medication reviews. We were told the practice was in the process of reorganising medication and annual health reviews. Longer appointment were available for health checks that coincided with the month of the patient's birthday. In this was the practice hoped to encourage patient attendance and gain a more comprehensive coverage of chronic disease monitoring.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to ensure improved care, treatment and outcomes for patients. The practice had a number of clinical audits, we looked at six. All were completed audits where the improvements made were implemented and monitored. For example; an audit of prescribing where there was a risk of interaction between two medicines. Results were analysed and discussed in clinical meetings and learned from. Patients were written to and advised that their repeat prescription would be amended to fit in with a more appropriate medicine in line with national guidelines. This was then re-audited two months later and showed that there had been a marked reduction in the joint prescribing of the interacting medicines. It also evidenced that, of those patients written to, following the first audit, no adverse comments were found in either a letter or consultations notes. The practice had noted therefore that this type of medication change could be dealt with by letter rather than in a face to face consultation. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. We saw that additional training was also available for staff including domestic violence awareness training which all staff had undertaken. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care, planning and co-ordination of care, support for family and carers and care plans were routinely reviewed and updated. Staff we spoke with told us the clinicians and management team were all very approachable and supportive and they were confident they could raise concerns regarding patients with them. We saw that this also took place during clinical meetings and the minutes we reviewed confirmed this took place.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear, the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, military veterans, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. Smoking cessation advice was available from a local support group. Patients who may be in need of extra support were identified by the practice.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 79.85% which was comparable to the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Childhood immunisation rates for the vaccinations given were comparable to CCG/ national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69.1% to 98.1% and five year olds from 84.5% to 98.3%. The practice provided telephone reminders for

Good

Are services effective?

(for example, treatment is effective)

families who did not attend for their childhood vaccinations. Flu vaccination rates for the over 65s were 74.85%, and at risk groups 53.82%. These were also comparable national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice identified patients requiring additional support and offered signposting for patients, their families and carers to a range of organisations such as Help the Aged and Suffolk Family Carers. They kept a register of all patients with a learning disability and were aware of the numbers that had registered with them. Of the 76 patients on the learning disability register, 26 had received a health care review in the previous 12 months. These patients attended the practice for their annual review of their condition. Care plans in place were the subject of reviews.

The clinicians provided patients with referral to a health trainer, who attended the practice weekly to support patients in improving their mobility, manage body weight and maintain a healthy lifestyle. Patients were also referred to local slimming clubs or walking groups to improve their lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 15 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when patients needed help and staff provided support when required. We spoke with three members of the patient participation group (PPG) on the day of our inspection and received written feedback from a fourth member who was unable to attend the surgery on the day to meet us. They all told us they were very satisfied with the care provided, we were told they felt lucky to be registered with the practice and felt their dignity and privacy was always respected.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was comparable to CCG and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG national average of 89%.
- 87% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 92% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 91% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 90%.
- 83% patients said they found the receptionists at the practice helpful compared to the CCG and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 86% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%

We saw examples of where staff had provided additional support to patients, for example ensuring vulnerable or older patients with memory issues attended their hospital appointments by collecting them from their home and coordinating their collection with the hospital transport services. Supporting vulnerable diabetic patients to ensure their insulin was administered daily. There were also systems in place to arrange for patients prescriptions to be delivered to a preferable location, for example a patients workplace. The practice manager described how staff had collected prescriptions for patients with limited mobility who were unable to collect themselves and how staff had safely escorted patients to their home following their appointment in severe weather.

Staff told us that translation services were made available for patients who did not have English as a first language. An electronic appointment check-in system was available to reflect the most common languages in the area and the

practice website had a facility to translate the information into over 80 languages. Staff had access to interpretation and translation services and were able to describe examples of how interpreters were requested to attend the surgery to provide support to patients when required. We saw notices in the patient information folders in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

There were patient folders and notices in the patient waiting room advising patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were identified as carers and were being supported, for example, by offering health checks and referral for social services support. Written information was available for carers to ensure they understood the various avenues of support available to them. The practice also ensured patients who were military veterans were identified and a read code added to their records to ensure they received additional support where required.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a telephone call or sympathy card. This was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. There was a notice board in the administration area which discreetly highlighted vulnerable or recently deceased patients. In addition there was an electronic alert on the computer system to ensure all staff were aware of the death and to avoid inappropriate communication. We heard how compassionate and kind the GPs and nurses were with regard to end of life care and how they had supported patients through bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice were aware of a potential influx of refugees to the area and were in discussions with the CCG in regard to allocation of services.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- The practice offered a 'Commuter's Clinic' on a Thursday evening until 8.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.
- The practice facilitated the attendance of the Deaf Association van, this provided hearing aid servicing and repairs for patients. In addition the practice acted as a recognised centre for the replacement of hearing aid batteries throughout the year.
- The practice reviewed patient admissions data monthly.
- The practice worked with the local learning disabilities team to ensure patients on the practice learning disability register had been correctly identified and received the correct support.
- A diabetic nurse facilitator was available and worked with the diabetic practice nurse at the practice.
- Saturday morning influenza clinics were available for patients over 65 or at risk of flu.
- There were nurse led chronic disease and wound care clinics available.
- There were disabled facilities, hearing loop and translation services available.
- The practice worked closely with multidisciplinary teams to improve the quality of service provided to vulnerable and palliative care patients. Meetings were minuted and audited and data was referred to the local CCG.
- The practice worked closely with the medicines management team towards a prescribing incentive scheme (a scheme to support practices in the safe reduction of prescribing costs).
- Online appointment booking, prescription ordering and access to basic medical records was available for patients.
- The practice liaised closely with local pharmacies where prescription collection and delivery service were available.
- Text services were available for patients who provided a mobile telephone number. These were used to confirm appointments, send reminders and other practice information to patients.
- The practice provided general health advice including a monthly sexual health clinic to young people. In addition appointments were available to young people registered with the practice where they could receive health advice or treatment including sexual health services.
- The practice ensured chlamydia kits were easily accessible for young patients.
- Emergency contraception was available at the practice. In addition the surgery was a venue for the C Card scheme, this ensured patients between the ages of 13 to 24 years could register to get a range of information, advice, free condoms, femidoms and other contraception.
- Some of the GP partners undertook out of hours sessions to ensure continuity of care to the practice patient population.
- One GP worked closely with local paramedics to ensure appropriate hospital admissions.

Access to the service

The practice was open between 8am and 6pm Monday to Friday. Appointments were from 8.30am to 11.30am every morning with GPs and 12 noon with the nurses and 2.30pm to 5.30pm daily with GPs, 1.30pm to 5.30pm with nurses Extended hours surgeries were offered on Thursday evenings from 6.30pm to 8.30pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Telephone consultations were available with GPs or practice nurses.

Results from the national GP patient survey published on July 2015 showed that patient's satisfaction with how they

Good

Are services responsive to people's needs?

(for example, to feedback?)

could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 80% of patients were satisfied with the practice's opening hours compared to the CCG and national average of 75%.
- 65% patients said they could get through easily to the surgery by phone compared to the CCG and national average of 73%.
- 74% patients described their experience of making an appointment as good compared to the CCG average of 74% and national average of 73%.
- 63% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG and national average of 65%.

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.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

All staff were aware of the complaints procedure and were provided with a guide that helped them support patients and advise them of the procedures to follow. Complaints forms were readily available at reception and the procedure was published in the practice leaflet.

Patients we spoke with had not had any cause for complaint. We saw that complaints recorded in the last 12 months had been dealt with in a timely manner and learning outcomes had been cascaded to staff within the practice. A summary of each complaint included, details of the investigation, the person responsible for the investigation, whether or not the complaint was upheld, and the actions and responses made. We looked at the most recent complaints the practice had investigated. We saw that these had all been thoroughly investigated and the patient had been communicated with throughout the process. The practice was open about anything they could have done better, and there was a system in place to ensure learning as a result of complaints received was disseminated to staff.

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 deliver high quality care and promote good outcomes for patients. The practice aims were to 'promote the principles of high quality and evidenced based care and preserve consistency for its patients'. The practice objectives were to 'provide a personal based service based on continuity of provision of care'.

Throughout our visit we saw a consistent, kind, caring and compassionate approach to patients that supported this assertion. The practice leadership team were aware of the importance of forward planning to ensure that the quality of the service they provided could continue to develop. The partners were committed to improving primary healthcare and recognised the value of training and staff development. It was evident from our interviews with the management team, the GPs and the staff that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that was patient centred and put patient outcomes first.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place. For example:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Clear methods of communication that involved the whole staff team and other healthcare professionals to disseminate best practice guidelines and other information.
- The GPs were all supported to address their professional development needs for revalidation. Staff were supported through appraisals and continued professional development. The GPs had learnt from incidents and complaints.
- There was a comprehensive list of internal meetings that involved staff. Patients and procedures were discussed to improve outcomes and these were then shared with an equally comprehensive list of meetings with external stakeholders.
- There were policies and procedures for every aspect of practice business. These included both clinical and administrative areas. Staff we spoke with had a clear working knowledge of them. Practice specific policies were implemented and were available to all staff through the practice intranet, a number of policies were available for patients on the practice website.
- The management team had a comprehensive understanding of the performance of the practice.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions
- The practice had completed reviews of incidents, compliments and complaints. Records showed that regular clinical and non-clinical meetings and audits were carried out as part of their quality improvement process to improve the service and patient care. Completed 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. Where audits had taken place, these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.

Leadership, openness and transparency

We found a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a lead for safeguarding, within the practice. Clinical staff also had lead roles in relation to their clinical expertise. There was a lead GP for a number of medical conditions for example asthma and diabetes. The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice for other areas.

We saw from the minutes we looked at that staff meetings were held regularly. Staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice and they had the opportunity, and were happy to, raise issues at team meetings or clinical meetings as appropriate. There was a willingness to improve and learn across all the staff we spoke with. Staff told us they felt the leadership at the practice was consistent and fair and generated an atmosphere of team working. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) both an active and a virtual group, and through surveys, compliments and complaints received. The practice continually worked to promote recruitment to the group. There was information about joining the PPG and the work they undertook in the patient information files in the waiting area and on the practice website. We saw the PPG had carried out annual surveys and met at regular intervals, we were told a GP was present when they met. Minutes of PPG meetings showed that compliments, comments and complaints were regularly discussed at PPG meetings. The practice manager showed us the analysis and action plan from the 2014 patient survey, which was considered in conjunction with the PPG. The practice liaised with the PPG and sought their advice with regard to the high incidents of patients who 'did not attend' (DNA) for their appointment at the practice. We saw the PPG and practice team had worked closely together to inform patients of the impact DNAs had on patients and practice resources. They had put actions in place to reduce DNAs and were continuing to work together to drive improvement. The practice also gathered feedback through the Friends and Family test, a comments box in the waiting area and questionnaires in the waiting area and on the practice website. For example patients were invited to respond to surveys on the phlebotomy service and the sexual health service provided at the practice. The September Friends and Family test showed 100% of patients who responded, would recommend the practice to friends or family. The practice produced a quarterly newsletter to inform patients of the latest news from the practice and any recent changes and actions from PPG meetings. This was available both in the waiting area and on the practice website.

The practice also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. We saw evidence of a staff training needs analysis to ensure all staff training requirements were addressed. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed GPs are required to demonstrate on a regular basis that they are up to date and fit to practise.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. Care and treatment provision was based upon relevant national guidance, which was regularly reviewed. The practice was recently accredited to provide training for students which included foundation year doctors and specialist or general practice training doctors who were training to be qualified as GPs. Some clinicians had areas of special clinical interest, for example one practice nurse had a specialist interest in sexual health, other nurses had specialist interests in diabetes and respiratory conditions. GPs had lead roles in chronic disease management such as asthma, heart failure, mental health and dementia. One GP partner undertook out of hours sessions to ensure continuity of care to the practice patient population and worked with a local project to provide telephone assessments and support and guidance for paramedics. This support covered complex issues such as assessing the mental capacity of patient who may decline admission to hospital following a 999 call. This was part of a project which we were told had run for six months and had seen an 85% reduction in admissions to a local hospital.

The practice team was forward thinking, had responded to the practices needs and worked together to improve outcomes for patients. We saw that the staff team had worked closely to recover and recycle equipment and resources from a recently closed NHS facility. This enabled the practice to upgrade and improve the surgery premises and facilities whilst recycling valuable NHS resources.