Constable Country Rural Medical Practice

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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Constable Country Medical Practice on 1 November 2015. This inspection was in follow up to our previous comprehensive inspection at the practice on 10 March 2015 where breaches of were found. The overall rating of the practice following the March 2015 inspection was inadequate and the practice was placed into special measures for a period of six months. We also issued requirement notices to the practice to inform them where improvements were needed. After the March 2015 inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to safe, effective, caring, responsive and well-led services.

At our inspection on 1 November 2015 we found that the practice had improved. The two requirement notices we issued following our previous inspection related to the safe delivery of care and good governance and both had been met. The ratings for the practice have been updated to reflect our recent findings.

The practice is rated as good overall, for providing safe, effective, caring, responsive and well led services.

Our key findings 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.
- Risks to patients were assessed and managed.
- 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 there were urgent appointments available the same day and that there was continuity of care, however we were told it was not always easy to make an appointment with the GP of their choice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a leadership structure and staff felt supported by the partners and business manager. The practice sought feedback from staff and patients, which it acted on.

There were areas of practice where the provider needs to make improvements.

Importantly the provider should;

- Improve the arrangements for the security of blank prescription forms.

I confirm that this practice has improved sufficiently to be rated Good overall. This practice will be removed from special measures.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

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 National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing 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, staff mentoring and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with, or higher than, others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients know about the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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. Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded 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. It had a clear vision and strategy for the delivery of high quality care and staff were

Summary of findings

working towards achieving it. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular team 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 upon. Staff had received inductions, regular performance reviews and attended staff meetings and events. There was an emphasis on seeking to learn from stakeholders, in particular through working with local practices, the local clinical commissioning group (CCG) and the patient participation group (PPG). This is a group of patients registered with the practice who have an interest in the service provided by the practice. An ethos of learning and improvement was present amongst all staff.

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.

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 patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were high 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. Appointments with GPs and nurses were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Patients we spoke with were positive about the services available to them and their families at the practice. 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 population group of the working-age people (including those recently retired and students).

Summary of findings

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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening at the practice 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 might make them vulnerable. Double appointment times were offered to patients who were vulnerable or with learning disabilities. Carers of those living in vulnerable circumstances were identified and offered support which included signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. The practice held monthly multi-disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible community psychiatric nurses to discuss vulnerable patients.

People experiencing poor mental health (including people with dementia)

Good

The practice proactively identified patients who may be at risk of developing dementia. The practice were aware of the number of patients they had registered with 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 then 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 such as the mental health charity MIND, Improving Access to Psychological Therapies (IAPT) and the community psychiatric nurse for provision of counselling and support. All the staff we spoke with had a clear understanding of the Mental Capacity Act and their role in implementing the Act.

Summary of findings

What people who use the service say

The national GP patient survey results undertaken prior to our original inspection in March 2015 and published in July 2015 showed the practice was performing below local and national averages. There were 137 responses and a response rate of 55%.

- 34% find it easy to get through to this surgery by phone compared with a CCG average of 81% and a national average of 73%.
- 75% find the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 87%.
- 19% with a preferred GP usually get to see or speak to that GP compared with a CCG and national average of 60%.
- 81% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 90% and a national average of 85%.
- 88% say the last appointment they got was convenient compared with a CCG average of 94% and a national average of 92%.
- 46% describe their experience of making an appointment as good compared with a CCG average of 79% and a national average of 73%.
- 66% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 68% and a national average of 65%.
- 42% feel they don't normally have to wait too long to be seen compared with a CCG average of 61% and a national average of 58%.

We spoke with seven members of the patient participation group (PPG). (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). Members told us the management team were cooperative. The PPG were enthusiastic and keen to help the practice improve. However we were told they were not convinced the ethos of the practice and the changes put in place were fully embedded at this time.

We spoke with 16 patients during our inspections at the main surgery and the second site at Capel St Mary. The feedback from patients was encouraging. 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, but not always with the GP of their choice. Patients told us they felt the staff were courteous and respected their privacy and dignity. We were told they felt confident in their care. We were told they were pleased with the improvements being made to the service provided and felt they received consideration from the practice team.

Areas for improvement

Action the service SHOULD take to improve

Importantly the provider should;

- Improve the arrangements for the security of blank prescription forms.

Constable Country Rural Medical Practice

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. In addition the team included a CQC pharmacist inspector and two CQC inspectors.

Background to Constable Country Rural Medical Practice

Constable Country Medical Practice provides primary medical services Monday to Friday from 8am to 6.30pm. There is a second site at Capel St Mary which we included in our inspection. The practice provides medical services to approximately 10,800 patients living in East Bergholt, Capel St Mary and the surrounding villages. Both the main surgery and the second site at Capel St Mary provide good access for patients with accessible toilets and neighbouring car parking facilities. The practice provides services to a diverse population age group, in a semi-rural location.

The practice has a team of five GPs meeting patients' needs, who hold managerial and financial responsibility for the practice. In addition, there are two nurse practitioners, one minor illness nurse, three practice nurses, two healthcare assistants, two phlebotomists, and a team of administration/secretarial and reception staff. The practice also employs a practice manager and deputy practice manager.

Constable Country Medical Practice is a training practice and GP registrars provide clinics throughout the year. Patients using the practice also have access to community staff including the community matron, district nurses, community psychiatric nurses, health visitors, counsellors, support workers, health visitors and midwives.

Following the previous inspection the practice had liaised with the CCG and local surgeries and had put a new appointment system in place. This went into operation in September 2015. There were a variety of appointments available daily at the practice, these included GP appointments, minor illness clinic appointments, nurse, telephone and pre-booked appointments. In addition pre-bookable appointments were available with either a GP or a nurse practitioner; urgent appointments were also available for people that needed them. Appointments were available with nurses from 8am and with GPs at 8.30am. Access to on-line appointments was available from 7pm the day before and 7am on the day

The practice did not offer extended hours appointments. However the practice worked with other practices as a 'hub' service. Patients could be booked into the 'hub service' extended hours appointments and electronic patient records could be accessed by the hub service once patients had provided their consent.

Detailed findings

Why we carried out this inspection

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.

This inspection was in follow up to our previous inspection at the practice on 10 March 2015, in which the practice was rated as inadequate overall. The practice was placed into special measures for a period of six months. Two breaches of the Health and Social Care Act 2008 were identified. The breaches related to the regulations for person-centred care and good governance. Two requirement notices were issued; the practice submitted an action plan to CQC on the measures they would take in response to our 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 2 November 2015.
- Spoke with staff and patients.
- Spoke with visiting health professionals.
- Reviewed patient survey information.
- Reviewed the practice's policies and procedures.

Good

Are services safe?

Our findings

Safe track record and learning

There were systems in place for reporting and recording significant events. Staff told us they were encouraged to report any concerns or incidents and would inform the practice manager or deputy practice manager of any incidents. There was a recording form available for staff to complete on the computer system. All significant events were then seen by the GP lead for significant events and were reviewed at staff meetings. The practice carried out an analysis of the significant events. People affected by significant events received a timely and sincere apology and were told about the actions taken to improve care. We saw that since the new system had been put in place over 80 significant events had been generated by staff with over 60 of these reviewed and any learning outcomes shared with the team. All clinical complaints received by the practice were treated as a significant event.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, where a patient's health might deteriorate in the waiting area, it was noted patient's privacy could not be protected. The practice had reviewed one incident and its procedures and as a result had purchased moveable patients screens to safeguard patient's privacy in the future.

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. There was GP lead for safety alerts, all safety alerts received by the practice were seen by the lead GP and practice manager. The lead GP oversaw any actions or audits required from the alerts and these were then discussed and reviewed at weekly clinical/partnership meetings. Where relevant these were shared and discussed with the nursing and/or reception teams at full staff meetings.

Staff knew the process for reporting significant events and could recall recent incidents. The lead GP oversaw the process of analysis including investigation. Following investigation, all events were discussed at monthly practice meetings. The practice had introduced a schedule of regular meetings to ensure all significant events were reviewed at appropriate intervals to ensure that any actions taken had been successful in reducing the risk of reoccurrence.

Overview of safety systems and processes

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

- The practice had policies in place for safeguarding children and vulnerable adults for staff to refer to. Contact details for local safeguarding referral teams were displayed at numerous points within the practice and staff knew their location. All staff had received appropriate safeguarding training. For example, the GPs had received training to level three as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014). Staff understood their responsibility to protect patients from avoidable harm. The practice nursing team also had level three training. Children who had been identified as being at increased risk of harm had their records flagged on the practice computer system. This gave the treating clinician oversight of the concerns and record links also extended to include other family members. 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, following our inspection we were assured that fire drills were undertaken at both sites. 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 and infection control and legionella.

- Appropriate standards of cleanliness and hygiene were followed. We observed both the main and the second site premises to be clean and tidy. There was a GP and practice nurse infection control clinical lead who were supported by the assistant practice manager. The practice had liaised with the local infection prevention teams to keep up to date with best practice and had recruited the services of an independent specialist infection control nurse who had worked with the practice infection control nurse and undertaken infection control audits across both the main practice site and the second site. The independent infection control nurse had also provided infection control training and audit training to the practice nurse. This audit had been undertaken in July 2015 and we saw evidence that action was taken to address any urgent improvements identified as a result, with a detailed action plan to address any low priority outstanding actions and reaudit in six months. For example, issues with clinical waste disposal had been reviewed with effective systems put in place. In addition following the CQC inspection in March 2015, hand washing sinks had been installed in the phlebotomy rooms at both the main and the second site surgeries. 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 throughout both buildings. There was an infection control protocol in place which all staff could access.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). 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. Prescription pads were securely stored however there were no systems in place to monitor their use through the practice. Medicines kept on site were stored safely and in line with manufacturers and nationally recognised guidance. For example, vaccines were stored safely and securely, at the correct temperature and were in date. A system of weekly and ad hoc checks took place to ensure that vaccines were fit for use. Nurses administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. The healthcare assistants administered a single vaccine when required; this was done in line with patient specific directions given by a GP.

- The practice had a policy and protocol to follow when recruiting staff. All staff had received enhanced checks through the Disclosure and Barring Service (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. Appraisals had taken place. All of the staff we checked had received appropriate training.

- Staff told us there were enough staff to provide a safe service to patients. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty we saw records which demonstrated 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 (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including 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. For example the GP lead reviewed all guidelines and cascaded a summary to each clinician. We looked at minutes of clinical meetings and saw these were regularly reviewed and discussed. The practice had also introduced a system of ensuring clinicians signed a record log to confirm they had seen and acted on any new guidelines. The practice then used this information to develop how care and treatment was delivered to meet patient needs. The practice monitored that these guidelines were followed through risk assessments and random sample checks of patient records. For example the practice had undertaken an audit of patients referred under the two week wait or urgent referral pathway for breast cancer.

We looked at the latest available data from both the NHS Business Authority (NHSBA) and the clinical commissioning group (CCG) on the practice levels for prescribing anti-inflammatory, antibacterial, antibiotic and hypnotic medicines. We saw that the practice levels of prescribing of these medicines were similar or better (lower) than the expected ranges when compared to CCG and national averages.

The practice offered a number of directed and local enhanced services. Enhanced services are the provision of services beyond the contractual requirement of the practice. Examples of enhanced services included childhood vaccination, minor surgery and avoiding unplanned admissions.

The lead GP coordinated the care needs of patients identified at higher risk of unplanned admission to hospital. Patients in this group had individual care plans that were reviewed regularly to determine and meet their social and care needs. Monthly meetings held at the practice with other health professionals included a community matron and community nurses involved in the care of patients.

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 for total achieved were 96.1% of the total number of points available, this was 2% above local CCG average and 2.6% above national average. The practice exception reporting was 5.9% this was 2.3% below the CCG average and 3.3% below the national average (where appropriate a practice may except a patient from a QOF indicator, for example, where patients decline to attend for a review, or where a medication cannot be prescribed due to a contraindication or side-effect). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed;

- Performance for diabetes related indicators were in line with both the CCG and national average. With the practice achieving 90.7%, this was 0.3% below the CCG average and 1.5% above national average.
- Performance for asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, epilepsy, heart failure, hypertension, learning disabilities, mental health, osteoporosis, palliative care, rheumatoid arthritis and stroke and transient ischaemic attack were better or the same in comparison to the CCG and national averages with the practice achieving 100% across each indicator.
- The dementia diagnosis rate was below national average.

The practice had introduced an audit cycle protocol in April 2015. Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We looked at eight clinical audits completed in the last two years; all of these were completed audits where the improvements made were implemented and monitored. Three audits had a second audit cycle completed. We saw there was evidence of learning and change within the practice following audits. For example, following an audit of two week wait referrals for patients with a suspected breast cancer, the GPs were committed to following the criteria set out for this referral pathway. Following an audit

Good

Are services effective?

(for example, treatment is effective)

of patients with a diagnosis of diabetes the practice had put in place regular reviews of patients hypoglycaemia awareness. The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example information provided by the CCG showed the practice continued to perform above the local average in reducing A&E admissions for patients over 75.

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 ongoing 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 had an appraisal within the last 12 months.
- Staff had been supported to develop in line with their personal development plans to enhance their skills. For example, the practice healthcare assistants administered flu vaccines under patient specific directions.
- The practice employed two experienced nurse practitioners; and a minor illness nurse. Nurses led in areas of disease management.
- Two GPs were GP trainers, in addition two GPs were honorary lecturers.
- GPs had special interests in disease management such as diabetes and conditions of the ear nose and throat.
- The practice was a post graduate teaching practice and an undergraduate teaching practice with the universities of Cambridge, East Anglia and Imperial College London. Doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. 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. This included care and risk assessments, care plans, medical records and test results. The practice had implemented a new protocol in April 2015 to ensure all correspondence coming in to the practice was forwarded to directly to the GPs for read coding, action and filing. However due to significant implications with GP workload this was discussed and reviewed with the local clinical commissioning group in August 2015. The practice then implemented a reviewed system to ensure all correspondence was seen by the GP with read coding completed by the administration team, this was then overseen by the GP for review and action. All GPs had undertaken training on processing and read coding clinical correspondence. We saw that communication letters and test results from hospitals, out-of-hours and other services were followed up on the day they were received. We saw the practice was up to date on the management of communications and test results.

The practice computer internet system had been restructured with defined areas. These areas included clinical, safeguarding, reception and management. The practice was in the process of updating policies and storing them in the system for all staff to access. Minutes of meetings and agendas were also stored on the shared drive and were available for staff to access. The practice was also in the process of commissioning an administration software system which would centralise all practice information and protocols into the one system. The practice anticipated this would significantly reduce much of the administration workload and provide a more effective and efficient process for document management.

Good

Are services effective?

(for example, treatment is effective)

We were told the system would also provide prompts to staff, for example to read minutes of meetings or check safety alerts and would provide an electronic audit trail of when this work had been completed.

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 ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. Information such as NHS patient information leaflets were also available for patients.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children living in vulnerable circumstances. These meetings were attended by district nurses and palliative care nurses. Meeting minutes reviewed included decisions made to ensure that patients received effective and coordinated care.

Consent to care and treatment

Patients' consent to care and treatment was 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.

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, 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. Patients who may be in need of extra support were identified by the practice. The practice had reviewed its process for completing health checks for patients with a learning disability. The new process ensured that all patients with a learning disability were proactively contacted to ensure they received an annual health check and the check was thorough. The practice nursing team offered annual health assessments for patients with a learning disability. We saw that of the 27 patients with a learning disability, 12 had received a health check, with a further 10 patients with a scheduled appointment arranged for their health check This assessment included weight, blood pressure and blood sample analysis. These checks could be undertaken at the practice or at the patient's home where it was difficult for the patient to attend the practice. Patients with a diagnosis of mental health were also encouraged to attend for a regular health check. We saw that of the 59 patients with a diagnosis of mental health on the register, 15 had received a recent annual health check and a further nine had an appointment scheduled for a health check. Any concerns identified were forwarded to a GP

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80.31%, which was comparable to the national average of 81.88% 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.

Childhood immunisation rates for the vaccinations given were above national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95.2% to 100% and five year olds from 95.6% to 98.9%.

Flu vaccination rates for the over 65s during the 2014/2015 flu campaign were 74.91%, and at risk groups 55.2%. This was the fourth highest immunisation rate for the Suffolk area and was also above national averages. We saw that over 2,000 eligible patients had already received a flu vaccination for the 2015/2016 flu campaign with further flu clinics scheduled and a programme of on-going opportunistic vaccination across all clinicians.

Patients had access to appropriate health assessments and checks. The practice did not offer routine health checks to all new patients registering with the practice, any health concerns identified from the new patient questionnaire were highlighted to the GP and the patient was then invited to make an appointment. Other health checks included NHS health checks for people aged 40–74. We saw the

Good

Are services effective?

(for example, treatment is effective)

practice had undertaken over 200 health checks in the current year to date. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

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. We saw 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.

Patients we spoke with said they felt the practice service had improved and staff were helpful, caring and treated them with dignity and respect. We were told staff responded compassionately when they needed help and provided support when required.

Results from the July 2015 national GP patient survey, undertaken prior to our original inspection in March 2015 and published in July 2015 showed the practice was below average for its satisfaction scores on consultations with doctors, however was in line/above CCG and national averages for nurse consultations (of the 249 surveys sent out, 137 surveys were completed, giving a 55% completion rate). For example:

- 71% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 68% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 80% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 67% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%.
- 93% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.
- 75% patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

The concerns identified through the July 2015 GP survey undertaken prior to March 2015 formed part of the review undertaken by the practice to improve its performance and a number of the systems put in place were actioned after the last survey. For example the new appointment system. In addition, in response to the results the practice had scheduled a number of training sessions for both the clinical and non-clinical staff with both outside agencies and the PPG on customer service care. These are detailed later in the report.

The practice had an overall commitment to never turn a patient away if they wished to see a GP and we were told this was working well for patients and GPs. The practice were engaged with the local Health watch team and had invited them to speak with patients at both the main and the second site surgeries about their experiences with the practice. They attended both sites in August 2015 before the new appointment system was implemented and were due to return in November 2015 to review their findings.

We received information from the practice following our inspection to confirm this had taken place. Health watch had attended both sites and had worked in conjunction with the PPG to interview more patients. The practice manager advised us that whilst their report had not been completed, he had received confirmation from both the PPG and health watch that feedback was significantly improved. We were told patients liked the new appointment system and were complimentary about staff and generally how helpful they were. We were told once the practice received this completed feedback this would form part of a practice meeting to review the appointment system and determine what further improvements were required.

Care planning and involvement in decisions about care and treatment

Results from the July 2015 national GP patient survey, undertaken prior to our original inspection in March 2015 and published in July 2015 showed patients responses were below CCG and national averages to questions about their involvement in planning and making decisions about their care and treatment and results were lower than local and national averages. For example:

Good

Are services caring?

- 75% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 58% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%

However, 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.

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 patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call 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.

Written information was provided to help carers and patients to access support services. This included organisations for poor mental health and advocacy services. Subject to a patient's agreement a carer could receive information and discuss issues with staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw the practice had responded to patient dissatisfaction with access by introducing a triage appointment system. The practice had worked with the CCG, the practice PPG and local GP surgeries to develop a bespoke appointment system. We looked at the appointment system and saw this ensured patients who needed advice from a GP were seen on the same day. The practice's new appointment system had been introduced in September 2015 and the practice continued to monitor its responsiveness to patient demand, through in house audit, NHS choices, the PPG, patient feedback and friends and family questionnaire feedback. The practice were planning a major review of the appointment system at the end of 2015. Information from appointment audits, health watch and PPG surveys would be used to form a clear picture of how effective the new system was. The system had already been adjusted to reflect on-going feedback. For example the practice had originally reserved an entire afternoon of appointments with a nurse practitioner. However, the practice had recognised that this number of appointments were not generally necessary. As a result of this the practice had adjusted this set of appointments by making half of them available for patients to book directly. We saw that nurse practitioners were better utilized to allow improved access to GPs for patients who wished to see or speak with a GP on the day. We were told the practice commitment to never turn a patient away was working well. The practice had analysed feedback from both NHS Choices and the friends and family results. We saw that of the 57 comments received before the new appointment system, 23 related to concerns about appointment availability. Of the 11 comment received following the introduction of the new appointment system, five related to appointments. However it was noted the comments made about appointments were positive and had improved significantly. For example patient feedback reported they were able to get an appointment on the same day or speak with a GP when required.

The practice had considered the needs of patients when planning services:

- Patients who were at the highest risk of unplanned admission were supported by individual care plans. If they were admitted to hospital, a GP contacted them when they were discharged to reassess their care needs.
- The availability of same day walk in appointments had increased. Patients told us this had made it easier to get a same day appointment.
- The practice nursing team included two nurse practitioners, one minor illness nurse and three practice nurses. One practice nurse provided a speciality family planning service. In addition health care assistants and phlebotomists ran a variety of appointments for long term conditions, minor illness and family health.
- There were nurse led chronic disease and wound care appointments available.
- The practice worked closely with local midwives to provide antenatal services, and GPs undertook all six week post natal and pre-school checks.
- There were longer appointments available for people with a learning disability. In addition health checks for patients with a learning disability could be undertaken in their home.
- 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 reviewed patient admissions data monthly.
- The practice did not offer routine health checks to all new patients registering with the practice. However information noted from the new patient questionnaire was highlighted to a GP and the patient would be asked to come in and see a GP. In particular where patients had been prescribed repeat medicines.
- The practice liaised closely with local pharmacies where prescription collection and delivery service were available.
- Patient and carer reviews were 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The practice worked closely with the medicines management team with a prescribing incentive scheme (a scheme to support practices in the safe reduction of prescribing costs). The practice were able to demonstrate a consistent reduction in overspend from 20.42% for April 2015 to 6.62% for September 2015.
- Online appointment booking, prescription ordering and access to basic medical records were available for patients.
- Chlamydia test kits were available at the practice.
- Emergency contraception was available at the practice.
- Community midwives and other health support workers provided services from the main surgery premises.
- The practice was in preliminary discussions with a local high school to provide support and a monitoring service for diabetic and asthma students. In addition to an early response service where required.

Access to the service

Following the previous inspection the practice had liaised with the CCG and local surgeries and had put a new appointment system in place. This went into operation in September 2015. There were a variety of appointments available daily at the practice, these included GP appointments, minor illness clinic appointments, nurse, telephone and pre-booked appointments. In addition pre-bookable appointments were available with either a GP or a nurse practitioner; urgent appointments were also available for people that needed them. Appointments were available with nurses from 8am and with GPs at 8.30am. Access to on-line appointments was available from 7pm the day before and 7am on the day. The practice did not offer extended hours appointments. We were told the practice worked with other practices as a 'hub' service. Patients could be booked into the 'hub service' extended hours appointments and electronic patient records could be accessed by the hub service once patients had provided their consent.

Results from the July 2015 national GP patient survey undertaken before the new appointment system was introduced, showed that patient's satisfaction with how they could access care and treatment was low in comparison to local and national averages. For example:

- 54% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 75%.
- 34% patients said they could get through easily to the surgery by phone compared to the CCG average of 81% and national average of 73%.
- 46% patients described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 66% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.

However patients we spoke with told us they were able to get appointments when they needed them and were happy with the changes to the appointment system. We saw that there were urgent appointments available on the day of our inspection and also pre-bookable appointments with GPs, nurses and healthcare assistants within one working day. The practice continued to monitor patient feedback following the introduction of the new system and had seen an improvement through patient responses to NHS choices and the Friends and Family test, with the practice rating increasing from 35% to 67% within the previous four months, for patients who would recommend the practice. In addition we noted an improvement in patient satisfaction comments on NHS choices from August 2015, with most comments responded to by the practice.

The practice had undertaken daily audits of the appointment system for the first two weeks following the introduction of the new system in September 2015. This was then extended to an audit of every other day to continually audit access and the impact of the new triage system.We looked at the results of these on-going audits which showed a clear improvement in a number of areas, for example a reduction in patients queuing outside the practice in the early morning for appointments. There was also evidence of increased use of the telephone triage system, extension to the GPs appointment times to accommodate those patients who wished to be seen on the day and the use of the on-line appointment system. The practice were continuing to audit the appointment system and a formal review meeting was planned with the lead GP and management team to investigate the effectiveness of the system. Once the results from this had been discussed the practice told us they then planned to look more in depth at each of the clinicians and the use of their appointments, to review their skills and utilised their

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointment availability even more efficiently. The practice manager told us the new appointment system was being continually adjusted on a daily basis to accommodate demand and seasonal influences.

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 clinical lead who handled all complaints in the practice alongside the practice manager. All complaints were reviewed as significant events and all significant events and complaints were distributed to all the GP partners for discussion, assessment and to identify potential learning. We saw these were discussed at clinical meetings and staff away days and learning had been disseminated across all teams.

We saw the practice had reviewed all complaints received in the previous 12 months to ensure these had been dealt with in line with their guidelines and where appropriate had been dealt with as a significant event. Staff told us they were encouraged to raise significant events/complaints since the previous inspection, and the GPs told us 80 had been generated since the new system was introduced, with over 60 reviewed and shared across all staff. We were told this had enabled the practice to identify trends and training needs across all the staff teams, however the new system had proved cumbersome and the introduction of a new electronic management workflow system was anticipated to improve the management of these. Learning from complaints was evident and when appropriate the practice had issued an apology and explained how systems had been changed to limit the risk of reoccurrence. For example, the practice had responded to patient complaints around access to appointments. In addition a sign in the reception areas advising patients of 'one problem per 10 minute appointment' had been removed.

We saw information was available to help patients understand the complaints system and the complaints process was displayed on the practice TV screens, practice leaflet and the practice website. Not all the patients we spoke with were aware of the process to follow if they wished to make a complaint. However patients told us they would ask the reception team or speak to the manager or GP.

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 excellent clinical care to every patient in a welcoming and supportive environment.

The objective of the practice was to achieve a CQC 'outstanding' rating within 3 years. To achieve this, the practice intended to focus on four strategic strands:

- Effective clinical and administrative governance and leadership
- Clinical excellence
- Organisational compliance and efficiency
- Innovative service delivery

The practice business plan reflected the vision and values and set out a comprehensive and detailed plan of action to support the objectives of the practice.

For example;

The practice planned to review its electronic system to ensure a) efficiency of clinical workflow (e.g. electronic referrals) is maximised and b) enable paperless clinical recording of clinically related information (e.g. care plans, multidisciplinary team working and actions plans etc.)

The practice planned to review how it managed patient contact. This included the use of nurse practitioners, triage, the appointment system and how different types of patient need were catered for e.g. medication queries, acute problems, long term disease management issues. In addition the practice planned to review how it could ensure the most efficient use of its clinical resources. This included the establishment of long-term disease management clinics, and clinics for patients with different needs and requirements.

We saw this was an area where the practice intended to fully engage with the PPG to help understand patient needs, in terms of their contact with the practice, and to actively participate in the development of the practice to meet these needs as effectively and efficiently as possible.

Governance arrangements

The practice had put in place 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 staff were aware of their roles and responsibilities. The practice manager was responsible for the day to day running of the practice; The GPs were all supported to address their professional development needs for revalidation. Staff were supported through appraisals and continued professional development. The practice had learnt from incidents and complaints.

The practice had a full range of policies and procedures in place to govern activity and these were available to staff on the practice's computer systems. We viewed a number of the practice's policies and procedures with last and next review dates. We were told the introduction of the new electronic management workflow system would provide an automatic audit trail for all documents read and reviewed by staff.

The practice was pro-active in identifying potential risks and challenges. This included health and safety, fire risk assessments and appointment audits, which were undertaken to ensure patient access was maximised and implementing mitigating actions. Equipment was checked for safety and accuracy.

The practice had completed reviews of incidents, compliments and complaints. Paper copies of all significant events were kept in a folder and a new log had been established and was available to all staff on the practice computer system. These detailed the issue, any actions and learning identified. We were told the practice planned to review all significant events again in December 2015 to ensure that all learning identified had been embedded in the practice. The practice then intended to review these annually.

We saw that regular clinical and non-clinical meetings had been carried out as part of their quality improvement process to improve the service and patient care. Minutes of meetings were available for staff through the computer system. We saw clinical audits had been undertaken and repeated to evidence that essential changes had been made to improve the quality of the service and to ensure that patients received safe care and treatment.

Leadership, openness and transparency

Staff told us that the GPs were more visible within the practice, were approachable and now took the time to listen to all members of staff. The improvement in the no blame culture within the practice was evident through the

Are services well-led?

Good

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

sharing of complaints and significant event reporting. The GPs told us they encouraged a culture of openness and honesty, this was confirmed by staff we spoke with. Staff told us they felt things at the practice had improved and their opinions were valued and supported. Staff told us that regular team meetings were held; they had the opportunity to raise any issues at team meetings or outside of meetings, were confident in doing so and felt supported if they did. For example staff were encouraged to raise significant events for review and discussion and to identify any learning requirements across the practice.

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

Following the previous inspection the practice had actively sought feedback from its patient population. The practice had written to each patient and an open evening was held at the practice where patients expressed their concerns though question and answer sessions and comment cards. From this meeting over 30 patients expressed an interest in forming a patient participation group (PPG). From this the practice had developed a core group of 13 members with a nominated chair and vice chair. The practice continued to work with health watch to develop the PPG and monthly meetings were held with a GP representative attending each meeting. PPG members had taken part in the practice flu clinic days, had visited other GP services to review their appointment systems and had provided additional comments box for patient feedback at both surgeries. In addition the practice manager and a GP had attended a coffee morning at the second site in Capel St Mary. The PPG had been invited to coordinate further attendance from the practice at other parish coffee mornings with the aim of seeking patient feedback. Patients were encouraged to provide feedback on NHS Choices; we noted these were responded to by the practice. Comments left on NHS Choices were distributed to the GP partners, together with comments from patients meetings and the friends and family results and were discussed at weekly partnership meetings. The first bi-annual audit of this data was reviewed by the practice in October 2015. The practice had updated its website with more patient information. In addition a PPG area had been established on the website and monthly practice updates including PPG updates were included in parish magazines.

We spoke with seven members of the PPG across both surgeries. We received comments that they continued to have concerns with the overall ethos of the practice and were concerned that systems and changes in place were not embedded. We were told the management team were cooperative and listened to members concerns. In addition the nursing team and reception staff were kind and supportive. The PPG members we spoke with expressed their enthusiasm to help the practice improve. However they were not convinced the GP partners would continue to encourage this.

The practice gathered feedback from staff through staff meetings, appraisals, suggestions box and informal discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. This was evident through the high number of significant event reporting staff had undertaken to highlight inadequacies and improve performance. Staff told us they felt involved and engaged to improve how the practice was run. The GPs commented on how effectively the staff team had pulled together during the previous six months to ensure safe and effective patient care and improve the practice performance. The practice produced its first monthly practice newsletter in May 2015 to keep staff informed of practice developments.

Innovation

The practice worked to ensure 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. There was a strong focus on continuous learning and improvement at all levels within the practice. Clinicians had areas of special clinical interest, for example, one GP had a special interest in diabetes and diseases of the ear, nose and throat. The practice was accredited as an undergraduate teaching practice with Cambridge, The University of East Anglia and Imperial College London. Two GPs were deanery approved trainers and two GPs were senior honorary lecturers. Practice nurses had specialist interest such as family planning and chronic disease management such as diabetes and respiratory diseases.

The practice had introduced a mentoring system for all staff across the practice both clinical and non-clinical to provide staff with support and guidance and identify training needs. Appraisals were undertaken. Other training for both clinical and non-clinical staff included customer service training scheduled for January 2016 in response to

Are services well-led?

Good

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

patient feedback. In addition the PPG had been invited to provide customer care training for reception staff at a future date. Lunch and learn sessions focusing on consultation skills were also scheduled, with leadership facilitation sessions with GPs and management teams scheduled for December 2015.