Care Quality Commission

Inspection Evidence Table

Walton Surgery (1-3080822235)

Inspection date: 13 August 2019

Date of data download: 5 August 2019

Overall rating: Good

Walton surgery was rated inadequate overall at their previous inspection in January 2019. Significant improvements had been made at this inspection and the practice is now rated as good.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Good

At the previous inspection in January 2019, the practice was rated as inadequate for providing safe services. Improvements had been made in relation to safeguarding, infection control and equipment had all been calibrated. Systems to ensure the appropriate monitoring of medicines and monitoring the work of the nurses and advanced nurse practitioner were embedded. Improvements had been made, which ensured patient correspondence was followed up in a timely way, major and significant health needs were coded, and diagnostic reports were reviewed appropriately. A failsafe system to monitor cervical cytology had been established and embedded. The practice is now rated as good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial[1]
Explanation of any answers and additional evidence: [1]The practice held a monthly multidisciplinary meeting to discuss safeguarding concerns, however this was not attended by the midwives, school nurses or health visitors. The practice held a separate meeting with the health visitor to discuss and review relevant information. The midwife held a weekly clinic at the practice and there was two-way liaison, as appropriate. Meeting minutes were recorded, and safeguarding issues were discussed on a one to one basis when required. The practice reported any safeguarding referrals to the Suffolk GP Federation C.I.C. via the electronic Datix system. The central governance team reviewed each event to ensure learning was shared across the wider organisation.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: There was a comprehensive centralised system for the management of recruitment and the oversight of mandatory training. There were reminders in place to check revalidation and registration of clinical staff.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Yes June 2019
There was a record of equipment calibration. Date of last calibration:	Yes June 2019[1]
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check:	Yes Annual
There was a log of fire drills. Date of last drill:	Yes January 2019
There was a record of fire alarm checks.	Yes Weekly

Date of last check:	checks
There was a record of fire training for staff. Date of last training:	Yes Various dates
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion:	Yes June 2019
Actions from fire risk assessment were identified and completed.	Yes[2]
Explanation of any answers and additional evidence: [1]Following the inspection in May 2019, a system had been established to monitor when equipment was due to be re-calibrated. The practice was in the process of streamlining the number of companies who completed calibration at the practice. At this inspection, we found this had been streamlined. [2]Actions highlighted in the fire risk assessment had been completed, which included repairing two fire doors.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Yes December 2018
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes December 2018
Explanation of any answers and additional evidence: A legionella risk assessment had been completed in June 2019. The risk at the surgery was deemed to be low and actions included taking monthly temperature tests of the water. We saw evidence to show this was due to start in August 2019 and the log had been started.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes[1]
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Yes 10 December 2019[1]
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: [1]The audit completed for Walton Surgery highlighted that the flooring required repairing or replacing and	

this had been completed. A hand hygiene audit was scheduled to be completed on a quarterly basis. This had been undertaken in July 2019 and no concerns had been identified. The two nurses at the practice were the infection control lead and deputy lead. They had both been employed since the previous inspection in January 2019. Suffolk GP Federation C.I.C. had obtained funding for additional training for the infection control leads. They reported feeling very supported in their role.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes[1]
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: [1]Training had been given to staff on what to do if a patient's health began to deteriorate in the waiting room or if there were suspected signs of sepsis.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes[1]
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays	Yes

in referrals.	
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes[2]
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Explanation of any answers and additional evidence:

[1]At the inspection in May 2019, systems had been established for managing incoming patient correspondence to ensure this was being dealt with appropriately, accurately and in a timely way and that patients were coded appropriately. Guidance was in place for staff managing incoming clinical correspondence. Managerial and clinical audit of this work had been established and was scheduled. Additional support to manage patient correspondence had been sourced for two days a week, which included arrangements for cover during staff absence and ad hoc support. At this inspection, we found the systems were effective and had been embedded. Staff who were responsible for managing patient correspondence reported that systems had improved, and they felt supported.

We reviewed the second audit cycle of clinical coding which had been completed in July 2019. This audit sampled the work of reception workflow administrators and non-clinical coders for 31 patient records. Checks were made in four areas; timeliness, accuracy, consistency and completeness. The target was 90% achievement in each of the four areas. 100% was achieved for timeliness, accuracy and consistency, with 97.9% being achieved for completeness. Individualised feedback had been given and performance had improved from the previous audit. Clinical coding audits were scheduled three monthly and monthly for new staff.

[2]At the inspection in May 2019, an effective failsafe system was in place for cervical cytology. The practice nurse kept a record of when cervical screening had been undertaken and that results had been received for each patient, which included information on inadequate samples. At this inspection, the system had been embedded. A second cycle audit had been completed in July 2019, which identified that two patients had not received a result. However, one sample had recently been taken, so no result was expected, and the other patient had refused but this had not been coded. This was an improvement from the May 2019 audit. A search was undertaken on the day of the inspection and two patients were identified, although both samples had recently been undertaken, so a result was not yet expected. The process of following up if a result had not been received, was known by relevant staff. The audit was scheduled to be undertaken monthly.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business	1.18	0.96	0.88	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
Service Authority - NHSBSA)				
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	10.1%	10.0%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	7.83	6.15	5.61	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.48	1.86	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance. (should do)	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes[1]
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes[2]
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and	N/A

Medicines management	Y/N/Partial
written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes[3]
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

[1]At the inspection in May 2019, we found there was clinical oversight of the competence of practice nurses, the advanced nurse practitioner and GPs. The clinical director of Suffolk GP Federation C.I.C. had undertaken a competency check of a sample of patient records for each clinician, which included appropriate prescribing. Feedback was shared with clinicians, with discussion on an individual basis in relation to the findings. At this inspection, we found this system had been embedded and staff we spoke with confirmed their practice had been reviewed and feedback given.

[1]Practice clinicians, which included locums, were aware of the prescribing data for the practice and continued to work to ensure appropriate prescribing. This included prescribing for uncomplicated urinary tract infection. Protocols and templates for specific medicines had been implemented to reduce prescribing. A list of named clinicians and their prescribing rates for a range of medicines, was shared and reviewed. Practice staff felt this had been effective in supporting the reduction of inappropriate prescribing. A review of patients prescribed a specific type of medicine was currently being completed, to ensure this was prescribed appropriately. The practice was able to demonstrate continued improvement to rates of antibiotic prescribing from January 2019, for the number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs.

[2]At the inspection in May 2019, we found systems had been established to ensure monitoring was undertaken for medicines which required this, before being re-issued. At this inspection, we found the systems had been embedded. We reviewed the records of patients prescribed medicines which required monitoring before being re-prescribed. Appropriate reviews had been undertaken for these patients. Reminder prompts had been set up on the practice's computer system.

[3]The Suffolk GP Federation C.I.C. had completed a risk assessment for emergency medicines which they did not keep in stock at the practice.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes

Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	58
Number of events that required action:	58

Explanation of any answers and additional evidence:

Staff were able to use a Datix system which was available on all computers to report events. Events were reviewed by the governance team and then the practice manager investigated the incident. The outcome was reviewed by the quality review panel to ensure the event was fully investigated and learning was then disseminated. Each incident was graded according to risk and the practice reviewed the key themes to mitigate against risks reoccurring. An action log was kept for all events and sent to the practices monthly. Significant events and identified learning were discussed and shared at practice meetings, which included practice team meetings and clinical staff meetings. Information was also shared through the 'Suffolk Fed' newsletter which all staff received.

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Locum clinician did not have access to computer system to print out cervical screening forms.	Administration staff have access to the computer system to ensure cervical screening forms can be printed for locum clinicians.
Laboratory unable to analyse blood from blood bottles, as they were out of date.	Patients rebooked for blood tests. Clinicians to check dates of supplies, which will be checked by healthcare assistant.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes[1]
Staff understood how to deal with alerts.	Yes[2]

Explanation of any answers and additional evidence:

[1] Suffolk GP Federation C.I.C. and the practice utilised the Datix system to action alerts. This included the alert, the date it was issued and a deadline for when staff needed to action the alert by. The alerts were received by the operations manager who emailed them to all clinicians. The alert was then actioned and overseen to completion by the primary care medical director. The actions taken were recorded on the Datix system.

[2] A new computer system protocol had been written; this linked to a template which highlighted medicines from safety alerts, or medicines with specific prescribing requirements. We reviewed four recent alerts and found patients were appropriately reviewed when required. The system established had been embedded.

Effective Rating: Good

At the previous inspection in January 2019, the practice was rated as inadequate for providing effective services. Improvements had been made to ensure appropriate prescribing and monitoring of medicines and that patients were followed up in a timely way, major and significant health needs were coded, and diagnostic reports were reviewed appropriately. A system was in place to monitor the work of the nurses and advanced nurse practitioner and to check they were not working outside of their competency. Improvements had been made to the clinical oversight of the Quality and Outcomes Framework (QOF) at a practice level.

The practice had started to use an appropriate tool to identify older people who were living with moderate or severe frailty. They had undertaken work with the learning disability nurse to review the coding of patients with a learning disability and the uptake of health reviews for people with a learning disability had increased.

Effective needs assessment, care and treatment

Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes[1]
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence: [1]Suffolk GP Federation C.I.C. advised they had sourced additional support following the previous inspection in January 2019. At this inspection, we reviewed patient records and found that patients had been reviewed, when necessary, and there was no patient correspondence which had not been acted upon in a timely way.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU)	1.04	0.65	0.77	No statistical variation

Prescribing	Practice performance	CCG average	England average	England comparison
(01/04/2018 to 31/03/2019) (NHSBSA)				

Older people Population group rating: Good

Findings
• The practice had started to use an appropriate tool to identify older people who were living with moderate or severe frailty. The practice planned to complete a clinical review including a review of medication and long-term conditions to reduce the need for multiple appointments. • The practice followed up on older patients discharged from hospital. They ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks were offered to patients over 75 years of age. • The practice worked with the community matron. District nurses attended the monthly multidisciplinary meetings. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. • All patient correspondence which identified a patient had sustained a fall, were sent to the nurse practitioner for review.

People with long-term conditions Population group rating: Good

Findings
• The practice had established a new approach for managing patients with long term conditions. Patients were sent a questionnaire to complete and bring to their first appointment. Blood tests were arranged as appropriate. Results were reviewed and patients requiring further intervention were booked into another appointment. The practice had prioritised patients based on clinical need to be recalled first. For patients with multiple long-term conditions, these conditions were reviewed together, when possible. • The practice QOF achievement and exception reporting for long term conditions including asthma, atrial fibrillation, diabetes and hypertension was in line with the CCG and England averages. The exception reporting for the percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was above the CCG and England average. We reviewed patient records from 2018/19 exception reporting and found examples where patients were not appropriately exception reported. We saw evidence that the process for 2019/20 had been amended so that exception reporting could only be completed by the primary care lead. • For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. • Staff who were responsible for reviews of patients with long term conditions had received specific training. • GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. • Adults with newly diagnosed cardiovascular disease were offered statins. • Patients with suspected hypertension were offered ambulatory blood pressure monitoring. • Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	68.9%	82.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	5.5% (13)	11.8%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	74.9%	79.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	4.6% (11)	8.2%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	81.5%	81.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	11.3% (27)	13.2%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	72.9%	77.4%	76.0%	No statistical variation
Exception rate (number of exceptions).	6.6% (15)	7.1%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.1%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	26.9% (28)	11.1%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	79.7%	83.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.2% (8)	3.7%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	89.2%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.8% (4)	5.9%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) target of 95% in three of the four areas.
- The practice contacted the parents or guardians of children due to have childhood immunisations. Children who did not attend were proactively followed up by the practice.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- Young people could access services for sexual health and contraception. Six staff at the practice had recently attended C-Card training and planned to offer this service imminently. (The C-Card scheme offers a private one to one consultation for young people aged 13 to 24 to get advice about sexual health and relationships.)
- GPs and nurse practitioners were trained and able to prescribe emergency contraception.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- Monthly meetings were held with the practice safeguarding lead and the health visitor to discuss and review cases.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of	29	31	93.5%	Met 90% minimum

DTaP/IPV/Hib) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	38	40	95.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	37	40	92.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	37	40	92.5%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The practice's uptake for cervical screening was 76%, which was in line with the CCG and England average, but below the 80% coverage target for the national screening programme. The practice provided information about cervical screening on their website and encouraged patients to attend opportunistically.
- The practice called patients who had received an abnormal test result to discuss it with the patient.
- The practice's uptake for breast and bowel cancer screening was in line with the CCG average and above the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had completed 138 health checks in the last 12 months.
- Patients could book or cancel healthcare assistant and some nurse appointments online and order repeat medication without the need to attend the surgery.
- The percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within 6 months of the date of diagnosis was lower than the CCG and England average. The practice had acted by training administration staff to run a monthly search for these patients, so they could be regularly reviewed, and new diagnoses were not missed.
- The practice had a palliative care register and there was clinical oversight of patients with palliative care needs.
- The practice planned to have a gold standard framework clinician attend the practice to give further training on managing patients at the end of life.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	76.0%	74.0%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	77.3%	77.8%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	54.5%	59.3%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	45.8%	65.0%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	51.5%	58.6%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• End of life care was delivered in a way which considered the needs of those whose circumstances may make them vulnerable. • The practice held a register of patients living in vulnerable circumstances which included those with a learning disability. • The practice demonstrated that they had a system to identify people who misused substances. • Clinical staff had completed learning disability health check training. • The practice had improved the uptake of health reviews for people with a learning disability, with ten out of 15 completed from April 2018 to March 2019. They had undertaken work with the learning disability nurse to review the coding of patients with a learning disability. Seven out of 14 patients with a learning disability had received a health review since April 2019. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for

physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

- There was a system for following up patients who failed to attend for administration of long term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- The practice had a mental health link worker on site who was available at the practice every week. They could also access a mental health nurse through the Walton Parish Nurses, a local Christian charity. The Suffolk GP Federation C.I.C. had worked with two local practices and employed two full time mental health nurses who worked across the three practices.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice QOF achievement for mental health was above the CCG and England averages. The exception reporting was above the CCG and England averages. This was due to the number of patients coded as in remission, which was appropriate in the examples we reviewed.
- The practice QOF achievement and exception reporting for dementia was in line with the CCG and England average.
- Same day and longer appointments were offered when required.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	91.3%	89.5%	Variation (positive)
Exception rate (number of exceptions).	25.0% (6)	14.0%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	92.3%	90.0%	Variation (positive)
Exception rate (number of exceptions).	20.8% (5)	12.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	74.1%	84.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.3% (3)	9.4%	6.6%	N/A

Any additional evidence or comments
The Suffolk GP Federation CIC monitored performance and exception reporting monthly, at the primary care review meetings.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	542.3	548.3	537.5
Overall QOF score (as a percentage of maximum)	97.0%	98.1%	96.2%
Overall QOF exception reporting (all domains)	4.0%	5.3%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes[1]
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years.

Suffolk GP Federation C.I.C. had a programme of audits that was monitored to promote quality improvement.

[1]We reviewed the second audit cycle of clinical coding which had been completed in July 2019. This audit sampled the work of reception workflow administrators and non-clinical coders for 31 patient records. Checks were made in four areas; timeliness, accuracy, consistency and completeness. The target was for 90% achievement in each of the four areas. 100% was achieved for timeliness, accuracy and consistency, with 97.9% being achieved for completeness. Individualised feedback had been given and performance had improved from the previous audit. Clinical coding audits were scheduled three monthly and monthly for new staff.

We reviewed the first audit cycle of prescribing a specific medicine as a proportion of a group of medicines. Prescribing rates had been identified for each GP. A target of 33% had been set, with all GPs currently prescribing above that target. Letters had been sent to patients to raise awareness of the effects of long-term use and to encourage reduction. Patients were being invited for a review.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes

There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes[1]
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: [1]At the inspection in May 2019, we found there was clinical oversight of the competence of practice nurses, the advanced nurse practitioner and GPs. The clinical director of Suffolk GP Federation C.I.C. had undertaken a competency check of a sample of patient records for each clinician. They had sampled a range of clinical consultations and reviewed the following: record of current medication, allergies, relevant social history and potential safeguarding concerns, appropriate examination findings, appropriate diagnosis and differential diagnosis, management appropriate to diagnosis, appropriate prescribing and detailed safety netting. Feedback was shared with clinicians, with discussion on an individual basis in relation to the findings. At this inspection we found the system had been embedded and staff we spoke with confirmed their practice had been reviewed and feedback given. Staff we spoke with confirmed that they had no concerns that anyone was working outside of their competency.	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence: The practice worked with Walton Parish Nurses, a Christian charity who supported people in the Walton community and included access to a registered nurse, a mental health nurse and an occupational therapist. An information board was available in the practice's waiting room to raise awareness of the services available to patients from Walton Parish Nurses.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: A self-testing blood pressure machine was available for patients to monitor their blood pressure. Patients were asked to share their results with reception staff who followed guidance based on the results.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.2%	95.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.7% (8)	0.8%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	N/A

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	22
Number of CQC comments received which were positive about the service.	17
Number of comments cards received which were mixed about the service.	Five
Number of CQC comments received which were negative about the service.	Zero

Source	Feedback
Patient interviews.	Patients were treated with kindness and respect by practice staff.
Compliments log.	The practice kept a record of compliments and thank you cards were displayed in the reception area. Comments included being thanked for support and care by practice staff. Thank you cards from colleagues were also displayed.
Feedback from CQC comments cards.	The comment cards we received where generally positive about the service. Comments included that clinicians took the time to explain treatment and were friendly, approachable and listened. There were also positive comments relating to the nursing team.
Feedback from care home representatives.	Clinical staff were caring, and patients' care and treatment was individualised. Patients were seen in their own room and privacy and dignity was maintained.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population

4420	273	116	42.5%	2.62%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	92.9%	89.9%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	92.0%	88.7%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	97.8%	95.7%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	92.1%	86.3%	82.9%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes

Any additional evidence	
Friends and Family test.	The practice had an electronic friends and family feedback system and patients were encouraged to leave rated feedback on the service they had received. The latest data from April to June 2019 showed from 71 respondents, 92% were extremely likely or likely to recommend the practice. Comments included that staff were helpful, caring and thorough.
Suggestions Box	The practice had a box in the waiting room for patients to give their suggestions. Suggestions for improvements were also provided from the friends and family test. There was a 'You said, we did' notice in the waiting room, where the practice provided feedback to patients on suggestions which they had acted upon. For example, there was now a self-testing blood pressure machine in the waiting room for patient use, with results being handed in to reception staff, for recording in patients notes

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Patient information was available in the waiting room, which included information on a range of local and national services, support groups and services available at the practice. Information could be made available in other formats, by request, for example the practice newsletter and the practice leaflet.	

Source	Feedback
Interviews with patients.	Staff listened and had time to discuss patients' needs and concerns.
Compliments log.	Comments included being thanked for support and care by practice staff.
Feedback from CQC comment cards.	Patients were involved in their care and treatment decisions and were given thorough explanation and time to make decisions.
Feedback from care home representatives.	Patients were involved in their care and treatment, which included carers and family members where appropriate.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	95.7%	94.1%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: Information about support groups was available via a link on the practice's website, and local telephone numbers were detailed on the practice leaflet, which was available online.	

Carers	Narrative
Percentage and number of carers identified.	The practice had 99 patients who were identified as carers. This was approximately 2% of their patient population. The practice was trying to ensure their carers register was accurate and a pop-up alert was in place on each patient record which prompted staff to ask the patient if they were/were still a carer.
How the practice supported carers (including young carers).	A range of information was available at the practice in relation to carers. This included national and local organisations and support groups. The citizens advice bureau (CAB) held a held a weekly clinic at the practice, where patients could turn up and seek advice and support. Where dementia was diagnosed or suspected, any carers for the patient were offered a health check.
How the practice supported recently bereaved patients.	Practical information was available on the practice's website for patients who were bereaved.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: The reception area was separate from the waiting room, so conversations could not be overheard. Notices were displayed for patients waiting to be seen at reception, to ask them stand back whilst they waited, and that a private room was available if needed. A mat with footprints on was placed away from the reception desk to encourage patients to wait there.	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Explanation of any answers and additional evidence:

The Suffolk GP Federation C.I.C. had worked with two local practices and employed two full time mental health nurses who worked across the three practices. They had also worked with the same local practices, one of which employed two paramedics who undertook home visits on behalf of the three practices. An on the day service was available, where patients could book urgent appoints and be seen between 3pm and 6.30pm each weekday. Responsibility for running this service was shared between the three practices.
The Citizen's advice bureau held a weekly clinic at the practice, where patients could turn up and seek advice and support.
Physiotherapy self-referral information was available on the practice's website.

A nurse practitioner undertook a weekly visit to a local care home to support with urgent needs and undertake long term condition management and medicines reviews, as appropriate. Other clinicians attended the care home, in response to urgent need and as appropriate.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 6.30pm
Tuesday	7.45am to 7pm
Wednesday	8am to 6.30pm
Thursday	7.45am to 6.30pm
Friday	7.45am to 6.30pm
Patients could book evening and weekend appointments with a GP through Suffolk GP+. (Suffolk GP+ is for patients who urgently need a doctor's appointment, or are not able to attend their usual GP practice on a weekday.)	
Appointments available:	
Monday	8.30am to 12.30 pm and from 2pm to 6pm
Tuesday	7.45am to 12.30 pm and from 2pm to 6.45pm
Wednesday	8.30am to 12.30 pm and from 2pm to 6pm

Thursday	7.45am to 12.30 pm and from 2pm to 6pm
Friday	7.45am to 12.30 pm and from 2pm to 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4420	273	116	42.5%	2.62%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	96.7%	95.1%	94.5%	No statistical variation

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Flu vaccinations were given to patients who were housebound.
- There was regular liaison between the community matron, district nurses and staff at the practice.

People with long-term conditions — Population group rating: Good

Findings

- The practice had established a new approach for managing patients with long term conditions. Patients were sent a questionnaire to complete and bring to their first appointment. Blood tests were arranged as appropriate. Results were reviewed and patients requiring further intervention were booked into another appointment. The practice had prioritised patients based on clinical need to be recalled first. For patients with multiple long-term conditions, these conditions were reviewed together, where possible.
- A diabetes specialist nurse held a clinic at the practice every two months to support patients with diabetes who had more complex needs. This was planned to be monthly from September 2019.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- The practice had recently made changes to pre-booked appointments so that they could be made up to twelve weeks in advance.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings
• There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances and who missed hospital appointments. Records we looked at confirmed this. • All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary. • Midwives held a clinic at the practice once a week. • Drop in clinics with a health visitor were not held at the practice but were available at various local locations.

Working age people (including those recently retired and students) — Population group rating: Good

Findings
• The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. • Patients could book evening and weekend appointments with a GP through Suffolk GP+. (Suffolk GP+ is for patients who urgently need a doctor's appointment or are not able to attend their usual GP practice on a weekday.) • The practice was open for pre-booked appointments from 6pm to 7pm on Tuesday evenings. • Patients could book or cancel health care assistant and some nurse appointments online. Repeat prescriptions could be requested online and by email. Telephone consultations were also available.

People whose circumstances make them vulnerable — Population group rating: Good

Findings
• The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. • The practice registered temporary residents on a rota basis agreed with other local practices. • Patients with sensory impairment were flagged on the clinical system to ensure appropriate care was offered at every intervention by all staff members. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. • The practice had a hearing aid loop to support patients with hearing impairment. • The practice had identified a range of vulnerable patients, by read code on the patients record. Care navigators were alerted when these vulnerable patients contacted the practice, they could seek additional clinical support directly, if needed.

People experiencing poor mental health (including people with dementia) Population group rating: Good

Findings
• Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly. There was a local dementia café which patients and their carers were signposted to. • Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff were knowledgeable in the mental capacity act. • The practice had good communication with the social work team and mental health nurses, through monthly multidisciplinary meetings, and referred patients with complex needs as appropriate. Where dementia was diagnosed or suspected, any carers for the patient were offered a health check. • The practice could access advice and support from one of two mental health nurses who had been employed to work across three local practices.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: The practice had pre-bookable appointments and appointments available on the day. Reception and administration staff answered telephone calls, with staff prioritising this at peak times. In conjunction with two local practices, the practice offered an 'on the day' service for patients with urgent needs, which was available from 3pm to 6.30pm. Appointments for this service could be accessed through the practice, although the location of the appointments differed depending on who was running the service that day. Staff advised that delays did not occur frequently, but if they were delayed, they would inform reception staff, so they could inform patients of the delay.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to	86.6%	N/A	68.3%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	84.3%	73.9%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	77.8%	69.8%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	84.7%	80.0%	73.6%	No statistical variation

Source	Feedback
Patient interviews.	Four patients we spoke with advised they were able to get an appointment when needed and were reviewed in a timely way. One patient advised of the difficulty in getting an appointment and another advised their medicines were not always reviewed in a timely way.
Feedback from CQC comment cards.	The comment cards we received were mostly positive about the service. Comments included that the continuity of care was good, that the patients had been able to see a doctor or nurse when required and positive satisfaction level with the appointments given. There were some mixed comments relating to the difficulty in getting appointments.
Feedback from care home representatives.	The practice was contracted to support one main care home, although they had some patients who lived in other care homes. The care home representative was satisfied with the service provided by the practice and advised that planned visits as well as request for urgent visits were accommodated well by clinicians at the practice. The practice worked with two nearby practices, one of which employed two paramedics, who undertook home visits to patients in each of the practices. The paramedic visited the care home for patients with urgent needs and a nurse practitioner visited weekly.
Healthwatch Suffolk. GP practices in Suffolk. A summary of patient feedback March 2018 - March 2019.Published June 2019.	The practice had received 34 reviews between March 2018 and March 2019. 44% were positive and they had a 3.1 out of 5 star rating. Since March 2019, a further nine comments had been received. Three were positive, which included excellent care in emergency situations, two were mixed and four were negative, with some dissatisfaction in relation to difficulty getting an appointment and alleged poor care. The practice had responded to comments to advise and invite patients to discuss any concerns.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	20
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Explanation of any answers and additional evidence:

Complaints were recorded on Datix and the Suffolk GP Federation C.I.C. governance team was responsible for corresponding with complainants. The practice was responsible for the investigation of the complaints and informed the governance team of their findings. Where appropriate, learning from complaints were shared within the practice team. Opportunities for this were available at the monthly practice meetings, clinical meetings and nurse's meetings.

The provider did not include the ombudsman details on the initial complaint response letters but did if the patient complained again. They told us they were changing this process to include these details on all response letters.

Example(s) of learning from complaints.

Complaint	Specific action taken
Language line not offered to patient.	Language line availability shared with reception team and advised to ask patients, as appropriate, if they would like to use language line.
Complaint regarding staff attitude.	The practice gained consent from the patient to review the complaint as it was originally made by a family member. The reviewed each point made in the complaint and fed back to staff regarding customer service.

Well-led Rating: Good

At the previous inspection in January 2019, the practice was rated as inadequate for providing well led services. Improvements had been made and systems and processes to ensure clinical leadership and governance at the practice were embedded. There was clinical oversight of patient correspondence. The backlog of patient correspondence had been completed and systems embedded to monitor completion of this work. Governance systems and processes established by Suffolk GP Federation C.I.C., were followed by practice staff.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes[1]
Explanation of any answers and additional evidence: [1] Suffolk GP Federation C.I.C. had completed a GP Future Leaders programme for GPs new to practice. This had been completed by the primary care clinical lead. Staffing changes had been made to improve clinical leadership at the practice; the primary care clinical lead provided clinical leadership at the practice, with senior clinical staff. Senior clinicians worked closely with non-clinical support staff, to enable upskilling of non-clinical roles with clinical oversight and monitoring. The operational manager worked one day a week at another site, with peers from other practices and leadership staff from the Suffolk GP Federation C.I.C. This provided direct leadership, guidance and support.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes[1]
There was a realistic strategy to achieve their priorities.	Yes[2]
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: [1] The aim for Suffolk GP Federation C.I.C. was: • "To find innovative solutions while at the same time protecting the interests of general practice	

and ensuring that patients continue to receive the very best care."

[2] The provider had a business plan in place that was continually monitored and updated when changes were made. For example, in the plan from April 2019, the practice did not have full care navigation in place. We found this was in place on the day of inspection.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes[1]
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes[2]
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

[1] Suffolk GP Federation C.I.C. had a GP Support hub available for GPs within the organisation, which included GPs at Walton Surgery. The support hub was available for access to support GPs, identify learning needs and offer opportunities within the organisation.

[2] Following the publication of the practice's CQC report 12 March 2019, the practice held an open event for patients to discuss the findings from the report and the actions the practice was taking. Feedback from patients and practice staff we spoke with, was positive about the meeting.

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviews.	Improvements had been made since the January 2019 inspection. Staff were very well supported and enjoyed their roles. Clinical leadership had improved, with clinicians being available. New ideas had been listened to and taken on board. Several staff members said it was a calm place to work.

Governance arrangements

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

	Y/N/Partial

There were governance structures and systems which were regularly reviewed.	Yes[1]
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

[1] Improvements had been made and there was effective safeguarding leadership and oversight by the safeguarding lead at the practice. Systems had been established and were embedded to ensure clinical oversight of the work of nursing staff and non-clinical staff undertaking patient correspondence workflow tasks.

The provider had an action log in place which covered several aspects of the service, including audits, incidents, risk assessments and complaints. This was used to continually review the actions required by the practice. For example, the health and safety audit for Walton Surgery highlighted that the practice required redecorating, and this was underway, with some areas completed.

The service had an incident management dashboard which identified all incidents that still required action. This was reviewed monthly and shared with practices. We reviewed this and found a downward trend of the number of outstanding actions.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes[1]
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes[2]
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

[1]The provider held monthly primary care meetings which were attended by all surgery leads and the medical director. We looked at meeting minutes which showed regular discussion of quality assurance including audits, performance (including QOF), significant events and incidents, risks within the practices and shared learning. This enabled the management board and the practice leads to share learning and implement systems to ensure risks were not replicated across sites.

[2] Systems and processes, for example in relation to the monitoring and management of medicines which require additional monitoring, had been embedded in practice. An effective failsafe system for cervical screening was in place.

The practice had streamlined the number of companies who completed calibration at the practice.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes[1]
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: [1] Practice clinicians, which included locums, were aware of the prescribing data for the practice and continued to work to ensure appropriate prescribing. A list of named clinicians and their prescribing rates for a range of medicines, was shared and reviewed. Practice staff felt this had been effective in supporting the reduction of inappropriate prescribing.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes[1]
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes[2]
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: [1] The practice had a twice yearly newsletter which was available on the practice's website and in the practice. Patients were informed of practice related changes and the reasons for these and were invited to share their views. [2] Suffolk GP Federation C.I.C. held a staff council, which Walton Surgery were a part of. The responsibility of this group was to be a champion for the workforce, represent the best interests of staff, embody the organisational values and support collective decisions. Suffolk GP Federation C.I.C. had completed a staff survey in 2018 which showed 91% of staff felt trusted to do their job. 85% of staff felt they were able to do their job to a standard they were pleased with. 84% were satisfied with the amount of responsibility they had. The 2019 staff survey was underway at the time of the inspection, so results were not available. Practice staff held a daily five minute 'huddle' meeting, where important updates were given from any member of staff, which may relate to the work of another staff member.	

Feedback from Patient Participation Group.

Feedback
The PPG had been established for approximately seven years and had twelve members who met face to face, every month. The number of PPG members had recently increased following a meeting arranged by the practice to share the findings from their January 2019 CQC inspection. A member of the management team always attended the meetings, with clinical staff and external organisations attending when requested. They reported the practice shared information about changes happening at the practice and were working to make the improvements required for their next CQC inspection. There was mixed feedback about how open the practice was to suggestions for improvement. One PPG member advised it had been suggested to change the order of the practice's website; which had been completed.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes[1]
Explanation of any answers and additional evidence: [1] Learning from complaints and significant events was shared across the wider organisation to encourage improvement.	

Examples of continuous learning and improvement
Reception staff had been trained in care navigation to enable them to effectively direct patients to the most appropriate clinician or person, without the need for a GP referral. The Suffolk GP Federation C.I.C. worked in partnership with two other local practices and had developed an on the day team for access to urgent appointments, access to two paramedics to support with home visits and access to two mental health nurses. Six staff at the practice had recently attended C-Card training and planned to offer this service imminently. (The C-Card scheme offers a private one to one consultation for young people aged 13 to 24 to get advice about sexual health and relationships.)

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.