

Care Quality Commission

Inspection Evidence Table

Martlesham Heath Surgery (1-5652858053)

Inspection date: 10 July 2019.

Date of data download: 25 June 2019

Overall rating: Requires Improvement

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

Safe

Rating: Inadequate

We rated safe as inadequate because:

- One of the nurses had started employment at the practice in July 2019 and although the Disclosure and Barring Service (DBS) was being applied for, this had not been received at the time of the inspection and the nurse had worked unsupervised with patients and this had not been risk assessed. The practice immediately completed a risk assessment. The practice confirmed the DBS check was received on 16 July 2019.
- Ongoing checks were not undertaken to ensure clinical staff remained registered with professional bodies.
- Patients who were prescribed medicines which required additional monitoring before being reissued, were not always monitored appropriately. We reviewed the records of eight patients and three patients had not received appropriate monitoring before these were reissued. The practice submitted evidence following the inspection to demonstrate that patients prescribed these medicines had been identified and had since received a blood test or were booked for one.
- The practice was not always reviewing blood monitoring results undertaken in secondary care before they reissued prescriptions.
- The system to ensure that safety alerts were actioned, and patients reviewed, if appropriate, was not always effective. We reviewed five safety alerts from 2019. Two of these alerts had been acted upon. For one alert, a search had been undertaken on 4 July 2019, and one patient had been identified, although this patient had not been reviewed. The practice agreed to review this patient and submitted evidence following the inspection that this had been completed. The other two alerts, which had been sent to dispensary had not been actioned. These were actioned on the day of the inspection and no patients were affected. Staff advised us during the inspection that they would add a task two days after the alert had been distributed for action, to confirm it was completed.
- There was not an effective failsafe system in place for cervical screening. Following the

inspection, the practice provided evidence to show that patients had received a result following a cervical screening test. They planned to undertake this search monthly.

- Two week wait referrals for suspected cancer were documented, but there was no system to check that appointments had been made. Following the inspection, the practice wrote a protocol and planned to code two week wait appointment letters. This was so they could undertake a weekly search to identify and follow up patients who had not received an appointment. The practice had searched for patients who had been referred in the last month and identified two patients whose appointment they would follow up, if it was not received the next day.
- Dispensing Standard Operating Procedures were not up to date and not signed by dispensing staff. There was no SOP for error management and near misses in the dispensary were not documented.
- There was no assessment of the competency of dispensing staff. This was last assessed in 2016.
- The practice recorded the expiry dates of medicines on receipt, and although dispensing staff advised they checked the expiry dates of medicines every three to four months, these checks were not documented.
- One health care assistant had completed safeguarding children training at level one, but had not completed this at level two, and one nurse had not completed safeguarding adult training. One GP had not received infection control training. One of the nurses was not up to date with their childhood immunisation training.

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse, but these were not always implemented.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial ¹
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial ²
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care	Y

Safeguarding	Y/N/Partial
professionals such as, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	
Explanation of any answers and additional evidence:	
¹ Two members of the nursing team had not completed appropriate safeguarding training; one health care assistant had not completed safeguarding children training to level two and one nurse had not completed safeguarding adult training.	
² One of the nurses had started employment at the practice in July 2019 and although the DBS was being applied for, this had not been received at the time of the inspection and the nurse had worked unsupervised with patients. We raised this with the practice who immediately completed a risk assessment to provide assurance that the nurse would not work unsupervised with patients until the DBS had been received. Following the inspection, the practice sent evidence that this had been received.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial ¹
Explanation of any answers and additional evidence:	
¹ The practice checked the registration of clinical staff when they commenced employment. They did not undertake any ongoing checks to ensure clinical staff remained registered. This was raised with the practice manager, who immediately added a check box onto the practice's human resources records log so that registration would be checked annually, and the check documented.	

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: 14/3/2019.	Y
There was a record of equipment calibration. Date of last calibration: 14/03/2019.	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 20/06/2019.	Y
There was a log of fire drills. Date of last drill: 28/6/2018.	Partial ¹
There was a record of fire alarm checks. Date of last check: 9/7/2019 (and undertaken weekly).	Y

There was a record of fire training for staff. Date of last training: various dates within the previous year.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 21/05/2019.	Y
Actions from fire risk assessment were identified and completed.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <p>¹ A fire risk assessment had been completed by an external company on 21 May 2019 and they had advised for fire drills to be undertaken every six months. The practice had not conducted a fire drill since June 2018; however, they had identified a date for their next fire drill.</p> <p>² The practice were in the process of completing actions from the fire risk assessment. For example, a system to check the emergency lighting monthly had been completed and fire equipment training was being arranged.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 10/4/2019.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/4/2019.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>¹ Health and safety risk assessments had been completed and the practice were in the process of completing actions from these. For example, they needed to clarify responsibility for updating COSHH assessments with the cleaners.</p> <p>A legionella risk assessment had been completed on 3 October 2018. Monthly hot and cold water temperature checking had started on 13 June 2019. This was because staff responsible for this were unsure of their role in relation to monitoring this. The five-year fixed wiring check was due in May 2019 and had been booked for 18 July 2019.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y ¹
Staff had received effective training on infection prevention and control.	Partial ²
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 30/5/2019.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

¹ There was an infection control risk assessment and plan. This was not dated, although an action had been updated in writing on the plan in April 2019. The practice's infection control lead had recently left, and this role was being taken over by the practice nurse who commenced employment in July 2019. They were planning to undertake a new infection control risk assessment and action plan.

² One of the clinical staff had not completed infection control training.

A range of audits had been completed, which included for example, hand washing, personal protective equipment, sharps and waste. These were scheduled and planned on an annual basis.

Cleaning schedules had recently been implemented, and we saw evidence that records of the cleaning had been documented according to the schedules. A system to audit the cleaning had been set up, although this was not due for completion at the time of the inspection.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: The practice had redesigned their entrance and waiting room area, so that patients could be observed, if necessary. They had also created a private room where patients could speak in private.	

Information to deliver safe care and treatment

Staff did not have all 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.	Y

There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial ¹
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹ There was a process to ensure that two week wait referrals for suspected cancer were sent from the practice to the hospital. However, there was no process to check that patients had received an appointment from the hospital. Following the inspection, the practice wrote a protocol and planned to code two week wait appointment letters. This was so they could undertake a weekly search to identify and follow up patients who had not received an appointment. The practice had searched for patients who had been referred in the last month and identified two patients whose appointment they would follow up, if it was not received the next day.</p> <p>² There was not a failsafe system in place for cervical screening, for all patients who had had a cervical screening test undertaken at the practice. Following the inspection, the practice submitted evidence to confirm that all patients who had had a cervical screening test had received results. They planned to undertake this search monthly.</p>	

Appropriate and safe use of medicines

The practice did not have 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 Service Authority - NHSBSA)	1.11	0.96	0.88	No statistical variation
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)	10.9%	10.0%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules,	7.66	6.15	5.61	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
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)				
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)	1.53	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.	Partial ¹
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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.	Y
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.	N ²
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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.	Y

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹ Dispensed medicine ready for collection, was stored in the dispensary. When dispensing staff were not present, reception staff handed out dispensed medicines to patients. The practice agreed to review this to ensure staff access to the dispensary was limited to dispensers and GPs.</p> <p>² We reviewed the records of eight patients who were prescribed medicines which required additional monitoring before being reissued. Three patients had not received appropriate monitoring before these were reissued. Following the inspection, the practice submitted evidence to show patients prescribed these medicines had been identified, and that an appointment for a blood test had been completed or had been booked.</p> <p>² The practice was not reviewing blood monitoring results undertaken in secondary care, before they reissued prescriptions.</p> <p>GPs were aware of their higher than 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. The practice advised they were working with the CCG to reduce this prescribing.</p> <p>The practice searched for patients who had been prescribed specific antibiotics, to ensure drug resistance was kept to a minimum. These were discussed at monthly clinical meetings to identify why they had been prescribed and whether an alternative would have been possible.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures (SOPs) which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	N ¹
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N ²
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Partial ³
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A

Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	N ⁴
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	N/A
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>¹ Dispensing SOPs were not up to date and not signed by dispensing staff. There was no SOP for error management.</p> <p>² There was no assessment of the competency of dispensing staff. This was last assessed in 2016. Dispensing staff had attended training and/or attended dispensing meetings and engaged with the pharmacist from the CCG.</p> <p>³ The practice recorded the expiry dates of medicines on receipt, and although dispensing staff advised they checked the expiry dates of medicines every three to four months, these checks were not documented.</p> <p>⁴ There was not a system to record near misses in the dispensary.</p>	

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial ¹
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y ²
Number of events recorded in last 12 months:	14
Number of events that required action:	14
<p>Explanation of any answers and additional evidence:</p> <p>¹ There was not a system to record near misses in the dispensary.</p> <p>² Documentation of the significant event and the identified learning was not always clear. For example, it was not clear what the significant event regarding a patient who returned an injectable medicine was, until we discussed this with the practice manager. The practice were in the process of changing how they recorded significant events, to a computerised system, with automatic prompts to complete.</p>	

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

Event	Specific action taken
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Patient had forgotten to make an appointment to have a significant type of medicine administered by a practice clinician and was overdue for this.	A monthly search was now completed to identify patients who have not attended for administration of this significant type of medicine. Follow up appointments are now made at the time of the initial appointment to minimise the risk of reoccurrence.
Unused boxes of an injectable medicine issued to a patient, (but not by the practice), were returned to the surgery. One was issued for administration in the patient's home by a district nurse.	The practice no longer accepts any unused medicine in any format and patients advised to return to the local pharmacy to be disposed of.
High maximum refrigerator temperature due to a stock take.	Data logger reviewed, and appropriate people contacted for further advice.

Safety alerts		Y/N/Partial
There was a system for recording and acting on safety alerts.		Partial ¹
Staff understood how to deal with alerts.		Y
<p>Explanation of any answers and additional evidence:</p> <p>¹ We reviewed five safety alerts from 2019. Two of the five alerts had been acted upon. For one alert, a search had been undertaken on 4 July 2019, and one patient had been identified. The practice agreed to follow up this patient. Following the inspection, the practice submitted evidence to confirm that the patients identified had been reviewed. The other two alerts, which had been sent to dispensary had not been actioned. These were actioned on the day of the inspection and no patients were affected. The system in place for managing safety alerts was discussed with the practice manager. They immediately amended the process for safety alerts, by adding a check two days after the alert was sent internally, to follow up that these had been received and were being acted upon.</p>		

Effective

Rating: Good

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial ¹
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: ¹ There was a process to ensure that two week wait referrals for suspected cancer were sent from the practice to the hospital. However, there was no process to check that patients had received an appointment from the hospital.	

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) (01/04/2018 to 31/03/2019) (NHSBSA)	1.19	0.65	0.77	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used an appropriate tool to identify older people who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- 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. All discharge letters with actions were reviewed by a GP.
- Staff had appropriate knowledge of treating older people including their psychological, mental

and communication needs.

- The practice worked with the community matron with regular liaison by telephone.

People with long-term conditions Population group rating: Good

Findings

- The practice QOF achievement and exception reporting for long term conditions including asthma, COPD, atrial fibrillation, diabetes and hypertension was in line with the CCG and England averages. Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice ensured that if blood tests were required, these were completed prior to the appointment with the nurse
- 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.
- The practice had a specialist nurse for diabetes and respiratory conditions, whose work was overseen by a GP. They acted as a resource and source of information to the practice team.

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)	79.4%	82.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	2.7% (7)	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)	68.3%	79.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	4.2% (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	84.4%	81.7%	80.1%	No statistical variation

cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	13.5% (35)	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) <small>(QOF)</small>	73.1%	77.4%	76.0%	No statistical variation
Exception rate (number of exceptions).	6.7% (25)	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) <small>(QOF)</small>	91.6%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	17.8% (18)	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) <small>(QOF)</small>	82.9%	83.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.6% (35)	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) <small>(QOF)</small>	90.2%	90.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.5% (2)	5.9%	6.7%	N/A

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were significantly above the World Health Organisation (WHO) target percentage of 90%.
- 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.
- Nurses 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.
- Vulnerable children were discussed as part of a standing agenda item at monthly clinical meetings.

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 DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	51	51	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	55	56	98.2%	Met 95% WHO based target (significant variation positive)
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) (01/04/2017 to 31/03/2018) (NHS England)	55	56	98.2%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	55	56	98.2%	Met 95% WHO based target (significant variation positive)

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
<ul style="list-style-type: none"> • The practice's uptake for cervical screening was 77%, which was in line with the CCG and England average, but below the 80% coverage target for the national screening programme. The practice were aware and invited patients opportunistically when they attended for other appointments. • The practice's uptake for breast and bowel cancer screening was in line with 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 166 health checks in the last 12 months.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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)	77.4%	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)	77.7%	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)	65.9%	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)	70.7%	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)	53.8%	58.6%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings
<ul style="list-style-type: none"> • End of life care was delivered in a way which took into account the needs of those whose circumstances may make them vulnerable. • The practice held a register of patients living in vulnerable circumstances including those with a learning disability. • The practice demonstrated that they had a system to identify people who misused substances. • The practice had 14 patients with a learning disability and had completed 11 reviews of patients with a learning disability in the previous 12 months. The practice were aware of why the other three patients had not attended for a review and planned to recall them, along with those who had received a review.

- 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 QOF achievement for mental health was in line with and above the CCG and England averages. The exception reporting was in line with the CCG and England averages.
- The practice QOF achievement and exception reporting for dementia was in line with the CCG and England average.
- 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. To help support the patient during this time, the practice contacted a friend or relative of the patient, after obtaining their consent, and asked if they could be with the patient, whilst additional support was being obtained.
- The practice had a mental health link worker on site who was available at the practice every week.
- 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.

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) <small>(QOF)</small>	100.0%	91.3%	89.5%	Variation (positive)
Exception rate (number of exceptions).	7.7% (3)	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) <small>(QOF)</small>	82.4%	92.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.8% (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) <small>(QOF)</small>	78.1%	84.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (2)	9.4%	6.6%	N/A

Monitoring care and treatment

The practice had a 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)	547.0	548.3	537.5
Overall QOF score (as a percentage of maximum)	97.9%	98.1%	96.2%
Overall QOF exception reporting (all domains)	4.5%	5.3%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years.</p> <p>The practice had completed an audit in December 2017 and repeated the cycle in December 2018 to ensure that patients who were prescribed a specific medicine had the correct shared care arrangement plan in their records. In 2017, 17 of the 18 patients had the correct paperwork in place. In 2018, 14 of the 16 patients had the correct paperwork in place. Actions were taken to ensure the appropriate shared care agreement was in place, for the two patients identified.</p> <p>The practice had completed an annual audit since 2017, to ensure all patients with a diagnosis of Parkinson's disease had a specialist annual review, according to evidence based guidance. 14 out of 14 patients had received this in 2017 and 19 out of 19 patients in 2018. In the 2019 audit, 18 out of 19 patients had received a review, however, one newly registered patient had not received a review; they were contacted and referred for specialist review.</p> <p>The practice audited cervical screening sample taking, recalls due to inadequate smears and labelling. This was to analyse the number of adequate and inadequate smears carried out by the practice nurses and to identify any learning.</p>	

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.	Partial ¹

The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N ²
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.	Partial ³
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice provided assurance that clinical staff had received clinical training and attended updates appropriate to their role. For example, the emergency care practitioner received support and supervision to undertake their role, from an identified GP. However, there was no assessment of the competency of dispensing staff. This was last assessed in 2016. The practice was not able to evidence that one of the nurses was up to date with their immunisation training.</p> <p>² The practice had obtained information about this course and planned to book the health care assistants onto this course, although one had started before this date.</p> <p>³ The management team had restructured how annual appraisals were going to be undertaken, so that these were devolved within the practice. An appraisal had been completed for one of the nurses and dates and paperwork had been sent out for the other staff.</p>	

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)	Y
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: The practice had developed information on a range of services which patients could self-refer to. These were displayed in the practice. Patients also had access to a self blood pressure monitoring machine in the waiting room. The results were printed out and patients were advised to take to the receptionist who entered them onto the record. Appropriate follow up was in place, 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)	94.1%	95.6%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.8% (28)	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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

The practice monitored the process for seeking consent appropriately.	Y
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.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	25
Number of CQC comments received which were positive about the service.	18
Number of comments cards received which were mixed about the service.	7
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient interviews.	Patients were treated with dignity and respect by staff in the practice. Positive comments were made in relation to the friendliness of staff.
Feedback from CQC comment cards.	Patients reported that staff were knowledgeable, helpful and professional. Patients reported they could get an urgent appointment, and most were satisfied with the wait for a non-urgent appointment.

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
6118	227	127	55.9%	2.08%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time	87.4%	89.3%	89.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)				
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 (01/01/2018 to 31/03/2018)	90.4%	87.6%	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 (01/01/2018 to 31/03/2018)	100.0%	95.4%	95.6%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	84.8%	85.8%	83.8%	No statistical variation

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

Any additional evidence	
Friends and Family data.	The practice had not received any friends and family feedback since May 2018.
The national GP patient survey.	The practice had reviewed the results from the 2018 survey and had an action plan in response to the three areas where they had scored below the CCG average. Some actions had been completed, for example, clinicians had received updated training in relation to mental health and were aware of local facilities for referral.
Practice survey.	The 'practice and patient group' (PPG) were currently undertaking a patient survey, which mirrored some of the questions from the national GP patient survey.
Comments on Healthwatch Suffolk website.	The practice had the Healthwatch Suffolk widget on their website, to obtain feedback on the service they provided. Healthwatch Suffolk published a report in June 2019, which collated patient responses between March 2018 and March 2019. From 29 comments, 48% were positive. Combined data from Healthwatch Suffolk ratings and The National GP Patient Survey data, identified that 81% (based on 110 patient responses) rated their overall experience as good. No further responses had been received and at the time of the inspection, the practice had a four out of five star rating.

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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Easy read and pictorial materials were available.	Y

Source	Feedback
Interviews with patients.	Patients were involved in decisions about their care and treatment and were given time to make decisions.
Feedback from CQC Comments Cards.	Patients were involved in care and treatment decisions and felt listened to, although three patients felt rushed during their appointment.
Interviews with care home representatives.	Care home staff confirmed that patients were involved in decisions about their care and treatment and family members were also involved, as 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 (01/01/2018 to 31/03/2018)	96.6%	93.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: The practice organised information in the waiting room into different areas. For example, there was a	

carers information board and feedback board which included information about the patient participation group, complaints and suggestions.

Carers	Narrative
Percentage and number of carers identified.	The practice had 109 patients who were registered as carers. This was nearly 2% of the practice population.
How the practice supported carers (including young carers).	A range of information was available on the practice's website for carers, which included for example, support and benefits, being a young carer and other sources of support and information. There was a carers information board in the waiting area which included a range of information, for example, young carers, accessing carers services and support groups.
How the practice supported recently bereaved patients.	Practical information was available on the practice's website to support bereaved patients. Information was also available in the practice. The practice sent condolence cards, as appropriate.

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.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: The practice had redesigned the reception and waiting room and a private room was available for patients who needed to speak confidentiality or who were distressed.	

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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Where vulnerable and frail patients were identified, the practice provided them with a direct telephone number to the practice. Staff received training to ensure this telephone line was responded to within two rings to ensure patients received an appropriate and rapid response to their requests for assistance. This ensured that such patients did not feel isolated.</p> <p>The practice provided a walk-in service to patients with minor injuries. These appointments were undertaken by a GP and a practice nurse, if the need was within their capability and competence.</p> <p>The practice was a registered clinic for yellow fever vaccinations.</p> <p>The practice had installed a new waiting room call system which had clearer visibility of the patients name when they were being called. The practice had also installed this as another method of sharing information with patients, for example in relation to the practice and health promotion.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm. 6.30pm to 9.30pm for pre-booked routine appointments only.
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8.30am to 12.30pm and from 3pm to 6pm.
Tuesday	8.30am to 12.30pm and from 3pm to 6pm.
Wednesday	8.30am to 12.30pm and from 3pm to 6pm. Evening pre-booked appointments from 6pm to 9.15pm.
Thursday	8.30am to 12.30pm and from 3pm to 6pm.
Friday	8.30am to 12.30pm and from 3pm to 6pm.

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.)	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6118	227	127	55.9%	2.08%

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 (01/01/2018 to 31/03/2018)	97.3%	95.3%	94.8%	No statistical variation

Additional evidence:

The practice had developed an action plan following their review of the 2018 national GP patient survey results. They planned to implement an internal patient survey, in response to three areas where they scored lower than the CCG average. This had been designed with the patient participation group and the survey was being implemented at the time of this inspection. The practice had undertaken additional training with clinicians to ensure they were up to date with mental health training and were aware of local facilities for referral. They had supported staff training to ensure they were aware of appointment options for patients and could effectively sign post to other facilities.

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 staff at the practice and district nurses and community matrons.

People with long-term conditions

Population group rating: Good

Findings

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- Patients with multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- A diabetes specialist nurse held a clinic at the practice every month to support patients with diabetes who had more complex needs.

- 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.
- 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

- Midwives held a clinic at the practice once a week.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- 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. GPs did not review all A&E discharge letters where children had attended due to injury, as non-clinical staff forwarded those where there were possible safeguarding issues. The practice amended their policy to include GP review of A&E discharge letters for all children who attended with injury.
- There was a separate children's waiting area, with child specific activities available.
- The practice had a private room, which patients could use to breastfeed.

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 9.15pm on Wednesday evenings.
- Patients could book online appointments and request prescriptions online. Telephone consultation 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 those with a learning disability.
- 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.
- Where vulnerable and frail patients were identified, the practice provided them with a direct mobile telephone number to the practice. Staff received training to ensure this telephone line was responded to within two rings to ensure patients received an appropriate and rapid response to their requests for

assistance. This ensured that such patients did not feel isolated.

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.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice had good communication with the local dementia intensive support team and referred patients with complex needs as appropriate. Where dementia was diagnosed or suspected, any carers for the patient were offered a health check.

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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2018 to 31/03/2018)	85.1%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	72.0%	76.2%	68.6%	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 (01/01/2018 to 31/03/2018)	72.2%	71.0%	65.9%	No statistical variation
The percentage of respondents to the GP	80.3%	80.4%	74.4%	No statistical

Indicator	Practice	CCG average	England average	England comparison
patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)				variation

Source	Feedback
Patient interviews.	Patients were able to obtain an urgent appointment, if appropriate and were satisfied that appointment times were convenient to them.
Feedback from CQC comments cards.	Patients reported they could get an urgent appointment, and most were satisfied with the wait for a non-urgent appointment.
Care Home representatives	Patients were reviewed as necessary on a weekly basis, usually by a GP who visited the home. Urgent home visits were also available, according to patients' needs.

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.	8
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Complaints information was available on the practice's website and on the patient feedback information board in the waiting room.</p> <p>The identification of the learning from complaints was not always clearly documented on the complaints log. The practice were in the process of changing how they recorded complaints, to a computerised system, with automatic prompts to complete.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
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Dissatisfaction with outcome of consultation with clinician.	Complaint investigated and responded to. Review of complaint at team meeting, agreed that complaint response letter could have been more apologetic for how the patient felt. Practice to be more apologetic in complaint responses.
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Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well led services because:

- The governance systems for recording the oversight of staff training was not always effective. Staff had not all completed training deemed mandatory for their role; for example, one health care assistant had only completed safeguarding children training to level one and one nurse had not completed safeguarding adult training. One GP had not received infection control training. One of the nurses was not up to date with their childhood immunisation training.
- The clinical governance systems to ensure that patients prescribed medicines which required a higher level of monitoring, were appropriately monitored, were not always effective.
- The clinical governance systems to ensure that safety alerts were actioned, and patients reviewed if appropriate, was not always effective.
- Staff were not always clear about their roles and responsibilities, which had led to some delays in establishing effective monitoring systems; for example, undertaking fire extinguisher checks and Legionella testing.
- There was not effective oversight of the dispensary service. Standard Operating Procedures were not all relevant, up to date or signed by dispensing staff and near misses were not documented. There was no assessment of the competency of the dispensing staff. This was last assessed in 2016. The practice did not document checks of the expiry dates of medicines. These issues had not been identified by the practice, although once they had been raised, the practice wrote an action plan to address these issues.

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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The practice had previously experienced staffing difficulties within the GP partnership. One of the GP partners retired in May 2018, although they had not been working at the practice for approximately one year prior to this. This had resulted in decreasing income and increasing workload. The practice applied for a resilience fund which they used to restructure clinical and non-clinical staff roles and responsibilities. The practice had not been able to recruit a permanent GP replacement until September 2018. The practice was part of Suffolk Primary Care, a group of 12 Suffolk GP practices, who worked together and shared resources to ensure patients received high quality healthcare.	

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.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice's philosophy and practice charter was written on the practice's website. The practice had a five year business plan, which identified current and potential issues and potential solutions to these. There was evidence of review, as some of the identified issues had been resolved.	

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	N ¹
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: ¹ The practice had a whistleblowing policy, but this did not make reference to a Freedom to Speak Up Guardian. Staff were complimentary about the leadership style and culture at the practice. They described it as friendly and supportive, with all staff being approachable, and their individual needs listened to and	

accommodated, where possible. The clinical team met for coffee every morning and discussed any patient concerns.

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

Source	Feedback
Staff interviews.	All the staff we spoke with felt very supported by the GPs and practice manager. Many of the staff had worked at the practice for a number of years and felt this was testament to the support received from the practice.

Governance arrangements

Systems for accountability to support good governance and management were not effective and staff were not all clear of their responsibilities and roles.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N ¹
Staff were clear about their roles and responsibilities.	Partial ²
There were appropriate governance arrangements with third parties.	Y

¹ There was not effective oversight and governance systems within the dispensary. Standard Operating Procedures were not all relevant, up to date or signed by dispensing staff and near misses were not documented. There was no assessment of the competency of the dispensing staff. This was last assessed in 2016. The practice did not document checks of the expiry dates of medicines.

One of the nurses had started employment at the practice in July 2019 and although the DBS was being applied for, this had not been received at the time of the inspection and the nurse had worked unsupervised with patients.

The system for recording the oversight of staff training was not effective. Staff had not all completed training deemed mandatory for their role. One health care assistant had not completed safeguarding children training to level two and one nurse had not completed safeguarding adult training. One GP had not received infection control training. One of the nurses was not up to date with their childhood immunisation training.

The system to ensure that patients prescribed medicines which required a higher level of monitoring, were appropriately monitored, was not effective. The system to ensure that safety alerts were actioned, and patients reviewed, if appropriate, was not effective.

A range of governance meetings were held, for example leadership meetings, significant event meetings, clinical meetings and practice meetings. However, the documentation of significant events and complaints and identified learning was not always clear or detailed. The practice were in the process of changing how they recorded significant events and complaints, to a computerised system.

² The practice had an organisational chart which included the tasks each staff member was responsible for. The practice had completed a staffing review, where staff had been assigned different roles, with their agreement and involvement; there had been some changes to this over time. Staff were not always clear of their roles and responsibilities, which had led to some delays in establishing effective monitoring systems for example, undertaking fire extinguisher checks and Legionella testing.

Shared care agreements were in place for patients prescribed a specific medicine which required monitoring.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance, although these were not effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N ¹
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial ¹
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y ²
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y ³
<p>Explanation of any answers and additional evidence:</p> <p>¹ There were not effective assurance systems in place for the dispensary. For example, SOPs had not been reviewed or signed up to by dispensing staff and competency assessments had not been undertaken since 2016.</p> <p>The practice did not undertake any ongoing checks to ensure clinical staff remained registered. Systems for ensuring the follow up of two week wait referrals for suspected cancer and ensuring results had been received for cervical screening sample were not in place.</p> <p>The overview of completed staff training was not up to date and did not provide effective oversight. Some staff had not completed training deemed mandatory by the provider and this was not known by the provider.</p> <p>² The practice had experienced a major disruption to their service at Christmas time in 2018 and although their response had been effective, they had still used this as an opportunity to learn.</p> <p>³ The practice had reviewed the roles of non-clinical and clinical staff and had involved staff in these discussions.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial ¹
There were effective arrangements for identifying, managing and mitigating risks.	Partial ¹
Staff whose responsibilities included making statutory notifications understood what this entails.	Y ²
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice had recently changed to a new system for e-learning training and some of the information on completed training courses was not available. There was an overview of all the training completed by staff, however this was not up to date, as there was evidence of training in staff files, which had not been entered onto the overview. The practice did not have effective oversight of completed training deemed</p>	

mandatory by the practice. Two nursing team staff members had not completed safeguarding training appropriate to their role, one GP had not completed infection control training and one nurse was not up to date with immunisation training.

² The registered provider of the service changed from a partnership to a single handed provider and the CQC registration of the provider had to change due to this. The practice submitted the appropriate applications and statutory notifications for the change to their registration.

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.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice had met with care home staff to review and improve the service provided. Care home staff were currently trialling an internal triage service, to review whether a GP needed to be called. The practice manager had met with Healthwatch Suffolk and regular engagement was established, which included sharing feedback obtained from patients.	

Feedback from Patient Participation Group.

Feedback
The practice and PPG liked to call this group the 'practice and patient group' (PPG). The PPG had been established for approximately eight years and had ten members who met face to face, every month. The practice manager usually attended the meetings and the GP partner attended some of the meeting. They reported the practice was very open to suggestions and encouraged and listened to the views of patients. For example, the PPG had been supported by the practice to obtain more members as part of the PPG recruitment drive in 2018. They had also tested and recommended a new website supplier, which the practice had actioned. Members of the PPG supported at flu clinics and changes were made to invite patients to four sessions by surname in alphabetical order, to improve the flow of patients, following feedback from the PPG. The PPG had also suggested extending the time frame for being able to book routine appointments, further than six weeks ahead, for example, blood tests. This has been actioned by the practice, as well as staff starting work before 8am so they could answer the telephones promptly at 8am. The practice also had a virtual PPG, to gather the views of more patients by email.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial ¹

Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: ¹ There was a system in place to support, monitor and review the work of the emergency care practitioner. However, not all staff had completed training deemed mandatory by the provider and competency assessments for dispensing staff had not been completed since 2016.	

Examples of continuous learning and improvement

The PPG had been approved for funding to undertake a falls prevention project for 24 patients at the practice. An information event had been held in May 2019 and participants over the age of 65 years were recruited, for three programmes. These will be held by a sports physiotherapist and will include for example exercise, diet and education advise for participants.

The practice were involved with the integrated neighbourhood team and had completed an information resource sheet for a range of services where patients could self refer.

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.