

# Care Quality Commission

## Inspection Evidence Table

### Hawthorn Drive Surgery (1-541292564)

Inspection date: 18 November 2019

Date of data download: 04 November 2019

## Overall rating: Good

The practice was previously rated requires improvement overall because systems to keep patients safe and to provide effective care were in place but were not always followed. At this inspection we found improvements had been made and established processes had been embedded.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

## Safe

## Rating: Good

- Improvements had been made since our previous inspection; staff had completed training deemed mandatory, recruitment checks were in line with the practice's recruitment policy, all staff had a DBS check every three years and the professional registration of staff was checked at recruitment and annually. An overdue hard wiring electrical check had been completed. Some improvements had been made to infection prevention and control; all staff had completed training and most audits demonstrated improvement.

### 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.	Y <sup>1</sup>
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.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y <sup>2</sup>
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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y <sup>3</sup>
Staff who acted as chaperones were trained for their role.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> The practice had a GP safeguarding lead, deputy safeguarding lead and a safeguarding administrator. Named staff were allocated to vulnerable families to maintain oversight.</p> <p><sup>2</sup> All clinical staff were trained to level three for safeguarding children and vulnerable adults. Non-clinical staff were trained to level two for safeguarding children and vulnerable adults.</p> <p><sup>3</sup> Improvements had been made to ensure all staff had a DBS check. The practice had a spreadsheet which detailed the date a DBS check had been completed for each member of staff. We reviewed three staff files and appropriate DBS checks had been completed. This included GP locums. The practice's policy was to request a DBS check for each staff member every three years. The practice was in the process of requesting and receiving updated DBS checks at the time of the inspection.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y <sup>1</sup>
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y <sup>2</sup>
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p><sup>1,2,3.</sup> Improvements had been made and recruitment checks were completed in accordance with the provider's recruitment policy. References had been obtained, staff vaccination history was known and annual checks of the professional registration of staff were made.</p> <p><sup>1,2,3.</sup> The practice had developed a dashboard which included DBS checks, staff immunisation, indemnity cover and professional registration. All staff had a DBS check and staff immunisation status was known, or in the process of being obtained. A process was in place to check the professional registration of staff at recruitment and annually. Identified staff were responsible for completing a range of checks and issues were raised with the partners as appropriate.</p>	
<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: June 2019.	Y
There was a record of equipment calibration. Date of last calibration: June 2019.	Y
There were risk assessments for any storage of hazardous substances for example, liquid	Partial <sup>1</sup>

nitrogen, storage of chemicals.	
There was a fire procedure.	Y
There was a record of fire extinguisher and emergency lighting checks. Date of last check: June 2019.	Y
There was a log of fire drills. Date of last drill: November 2019.	Y
There was a record of fire alarm checks. Date of last check: June 2019, external company. November 2019, weekly staff checks.	Y
There was a record of fire training for staff. Date of last training: November 2019.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: June 2019.	Y
Actions from fire risk assessment were identified and completed.	N/A <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> COSHH safety data sheets were available for hazardous substances used by the external cleaning company staff. The practice did not have these in place for hazardous substances which employed staff used and there was no risk assessment in place. Following the inspection, the practice obtained COSHH safety data sheets for these hazardous substances and assured us that relevant staff were able to access them.</p> <p><sup>2</sup> There were no recommendations from the fire risk assessment.</p> <p>The practice had completed a hard wiring electrical test of the premises in December 2018 and was found to be satisfactory.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: June 2019.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: June 2019.	Y <sup>1</sup>
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> A Legionella risk assessment had been completed in June 2018, with a health check completed in June 2019. Water temperature monitoring was undertaken monthly and issues raised with the partners for discussion and action at the partners meeting. A disability access audit had been completed in June 2019. A portable ramp had been recommended. This was previously recommended, but a decision made by the partners that this would not be installed due to the risk from ongoing traffic. The practice had increased their fire marshals from three to four and they had completed appropriate training for this role.</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
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: October 2019.	Y <sup>1</sup>
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: <sup>1</sup> The practice had reviewed their system for managing infection prevention and control and some improvements had been made. All staff had completed infection control training. The infection control lead undertook regular audits of sharps handling, hand hygiene, clinical room cleaning and vaccination storage. Improvements had been sustained in relation to actions identified and implemented in the overall infection control audit, hand hygiene audit, vaccine storage audit and sharps management audit. However, improvements were not sustained in the documentation of the cleaning of clinical rooms audit, which was undertaken in August 2019. A health care assistant had been identified to check the cleaning of the clinical rooms, following this audit.	

## 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 <sup>1</sup>
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: <sup>1</sup> The GP locum pack had been updated and included recent best practice prescribing guidance. This had been identified as an action following a recent antibiotic prescribing audit.	

## 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y <sup>1</sup>
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 <sup>2</sup>
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y <sup>3</sup>
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><sup>1</sup> Staff who completed summarising had received appropriate training. The practice was in the process of reviewing the clinical notes of all patients to ensure the coding was accurate.</p> <p><sup>2</sup> Some of the clinical staff had a system to monitor that patients who they had referred for suspected cancer had been seen. The practice identified 48 patients who had been referred for suspected cancer from 1 April 2109 to 30 June 2019. However, there was no protocol or process to check that all patients referred had been seen by the hospital. Following the inspection, the practice confirmed that 127 patients had been referred since 1 April 2019 to the date of the inspection. 124 of those patients had been seen, three referrals had been cancelled by the hospital. The practice submitted their new protocol to monitor patients referred for suspected cancer to ensure they had been seen or those who had not attended were reviewed.</p> <p><sup>3</sup> All test results were reviewed by a clinician.</p>	

## 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.15	0.95	0.87	Tending towards variation (negative)
The number of prescription items for	8.0%	9.1%	8.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)				
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 (01/01/2019 to 30/06/2019) (NHSBSA)	5.57	6.21	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	2.82	1.85	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
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).	Partial <sup>1</sup>
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 <sup>2</sup>
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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 <sup>3</sup>
The practice held appropriate emergency medicines, risk assessments were in place to	Y

Medicines management	Y/N/Partial
determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	
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.	Partial <sup>4</sup>
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> On the day of the inspection, we found that three PGDs appeared to have expired. Following our visit, the practice sent us evidence to confirm that the current PGDs were in use but had been misfiled. In response, the practice devised a PGD dashboard which detailed the different PDG's and expiry dates. They planned for this to be reviewed, to ensure all PDGs were in date and easily available for staff.</p> <p><sup>2</sup> The practice employed a pharmacist who undertook medicines reviews for patients, which included patients who lived in care homes. Feedback from patients and patient representatives was positive about the role of the pharmacist.</p> <p><sup>3</sup> The practice was aware of their antibiotic prescribing rates. They undertook prescribing audits and acted on identified areas for improvement. They monitored prescribing rates with support from the Clinical Commissioning Group.</p> <p><sup>4</sup> Medicines in one of the vaccine refrigerators was not stored to ensure appropriate air flow. The practice advised this was due to influenza vaccine stock being received and we received assurance that the integrity or safety of the medicines were not affected. Shortly after the inspection, we received confirmation that the provider had subsequently moved some of the stock to another vaccine refrigerator.</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.	Y
There was a system for recording and acting on significant events.	Y <sup>1</sup>
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	18
Number of events that required action:	18
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> Significant events were discussed at the monthly clinical meetings.</p>	

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

Event	Specific action taken
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Tasks were not classified according to urgency for completion.	Tasks were now classified according to their urgency for completion.
Sharps bin from patients not closed correctly.	Staff check patients' sharps bins have been closed correctly by the patient before accepting them for disposal.

<b>Safety alerts</b>	<b>Y/N/Partial</b>
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We checked two patient safety alerts which had been acted on and patients reviewed as appropriate.	



## Effective

## Rating: Good

At our last inspection the practice was rated as requires improvement for the population groups people whose circumstances may make them vulnerable, people with long term conditions and people with mental health needs because:

We found improvements had been made and these population groups are now rated good.

- 91% of patients had a review from April 2018 to March 2019. The practice had completed 54% of reviews of patients with a learning disability since April 2019.
- Improvements had been made to the overall QOF achievement for people with diabetes and chronic obstructive pulmonary disease. The achievement for diabetes was below the CCG average but was in line with the England average. The overall exception reporting for diabetes and COPD was in line with the CCG and England averages.
- The practice overall QOF achievement for mental health and dementia was in line with the CCG and England averages. The overall exception reporting for mental health and dementia was in line with the CCG and England averages.

### 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.	Y
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

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)	1.18	0.64	0.75	No statistical variation

Prescribing	Practice performance	CCG average	England average	England comparison
(01/07/2018 to 30/06/2019) (NHSBSA)				

## Older people

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. The practice pharmacist and health care assistant were involved in this review.</li> <li>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.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Older patients who lived in care homes received flu vaccinations during home visits.</li> <li>An emergency care practitioner visited patients in four care homes on a weekly basis. Patients who were prescribed medicines were reviewed by the pharmacist and GP, as appropriate. Care home staff knew how to contact them if they had any concerns.</li> </ul>

## People with long-term conditions

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The practice ensured that if blood tests were required, these were completed prior to the appointment with the nurse. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Improvements had been made and patients were invited by telephone to their review.</li> <li>Staff who were responsible for reviews of patients with long term conditions had received specific training.</li> <li>GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.</li> <li>Adults with newly diagnosed cardiovascular disease were offered statins.</li> <li>Patients with suspected hypertension were offered ambulatory blood pressure monitoring.</li> <li>Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.</li> <li>The practice had identified patients who had been coded as having heart failure. Two clinical staff had completed training and held a monthly clinic to review patient's diagnosis and offer appropriate intervention.</li> <li>The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.</li> <li>Patients who were housebound received a home visit for their annual review and influenza vaccination.</li> <li>Patients with long term conditions who lived in care home received flu vaccinations during home visits.</li> <li>The practice overall 2018 to 2019 QOF achievement for long term conditions including asthma,</li> </ul>

atrial fibrillation, chronic obstructive pulmonary disease (COPD) and hypertension was in line with the CCG and England averages. The overall exception reporting for all these long-term conditions was in line with the CCG and England averages.

- Improvements had been made to the overall achievement for people with diabetes and COPD. The practice's 2017 to 2018 QOF overall achievement was significantly lower than the CCG and England averages. This had improved from 75.7% to 84.5% for diabetes and from 85.7% to 92.7% for COPD in 2018 to 2019 data. The overall 2018 to 2019 achievement for diabetes was below the CCG average, but in line with the England average.
- The achievement for the percentage of patients with Chronic Obstructive Pulmonary Disease (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 had increased from 78.3% to 78.6%. The exception reporting had reduced from 13.7% (25 patients) to 6.3% (13 patients). The practice planned to review patients to ensure this had been completed for all patients and to ensure it was completed in future patient reviews.

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 (01/04/2018 to 31/03/2019) (QOF)	71.7%	83.5%	79.3%	No statistical variation
Exception rate (number of exceptions).	9.7% (47)	11.4%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	75.8%	80.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	8.7% (42)	7.9%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	71.2%	83.0%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	13.4% (65)	12.6%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	79.3%	78.1%	75.9%	No statistical variation

Exception rate (number of exceptions).	2.5% (15)	5.2%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	78.6%	92.1%	89.6%	Variation (negative)
Exception rate (number of exceptions).	6.3% (13)	9.9%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	85.3%	85.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.8% (34)	3.4%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.7%	92.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	9.8% (14)	5.5%	5.9%	N/A

#### Any additional evidence or comments

The practice had met with the Consultants from the Diabetes Centre and discussed and agreed arrangements for meeting QOF targets. The practice contacted all patients via text and telephone where appropriate, to improve attendance. Multi morbidity clinics had been established which the practice advised had improved attendance.

### Families, children and young people

### Population group rating: Good

#### Findings

- The practice met the minimum 90% target for all four childhood immunisation uptake indicators. The practice did not meet the WHO based national target of 95% for the four childhood immunisation uptake indicators.
- Children who did not attend were followed up by the practice.
- Opportunistic discussions were held to encourage attendance when children and parents attended other appointments at the practice.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- 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.

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	114	126	90.5%	Met 90% minimum
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)	119	129	92.2%	Met 90% minimum
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)	119	129	92.2%	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)	118	129	91.5%	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 74%, which was below the 80% coverage target for the national screening programme.
- The practice promoted the uptake of cervical screening through information displayed in the practice, and opportunistically with reminders on the patient's record.
- There was failsafe system in place for cervical screening to check that samples sent for analysis were received back.
- The practice's uptake for breast cancer screening was in line with the national average; bowel cancer screening was below the England average. The practice was aware of this data. Bowel cancer letters were issued on the patients 60<sup>th</sup> birthday and systems were in place to follow up patients who had not responded.
- 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 64 NHS

health checks in the last 12 months.

- The practice had an action plan to improve the review of patients with a new cancer diagnosis. The practice had a nominated administrative lead who reviewed all incoming patient correspondence which related to a new or ongoing diagnosis of cancer, to ascertain if a face to face review was necessary. Patients were contacted by telephone and offered a face to face review appointment. Following the appointment, a recall was set up for the patient for 12 months, or sooner if appropriate. A cancer care template had been developed to support clinical staff based on best practice advice of MacMillan cancer support. We reviewed the records of four patients with a new diagnosis of cancer in the past nine months and all patients had received a review.
- The practice invited other professionals to palliative care meetings, but attendance had not been possible; liaison with other professionals was undertaken as appropriate. The last palliative care meeting was in April 2019. Palliative care patients were discussed during daily and monthly practice clinical meetings. Identified actions were documented in the patient's clinical notes. The practice had 32 patients on the palliative care register and submitted evidence following the inspection that all patients had been reviewed within the previous five months.

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)	73.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	72.5%	77.8%	72.1%	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)	46.1%	59.3%	57.3%	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)	61.2%	65.0%	69.3%	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)	60.5%	58.6%	51.9%	No statistical variation

**People whose circumstances make them vulnerable**

**Population group rating: Good**

#### Findings

- The practice had reviewed their process for inviting patients with a learning disability for a health review. A clinical and non-clinical lead were identified and led this work. Patients were invited by telephone, which the practice advised had improved the engagement and uptake of health reviews.



- 91% of patients had a review from April 2018 to March 2019. The practice had completed 54% of reviews of patients with a learning disability since April 2019.
- Health reviews for people with a learning disability were undertaken in the patient's home where appropriate.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- 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 demonstrated that they had a system to identify people who misused substances.
- 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 overall QOF achievement for mental health and dementia was in line with the CCG and England averages. The overall exception reporting for mental health and dementia was in line with the CCG and England averages.
- The practice had reviewed their process for exception reporting. This was agreed only following review by a clinician. Some patients were invited by telephone and home visits were undertaken where appropriate.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice undertook regular screening of patients with memory issues.
- 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 employed a mental health practitioner who worked three days a week. Joint appointments with other professionals, for example, the practice pharmacist or a social worker, were held as appropriate.

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 (01/04/2018 to 31/03/2019) (QOF)	95.2%	92.6%	89.4%	No statistical variation

Exception rate (number of exceptions).	17.6% (9)	12.8%	12.3%	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 (01/04/2018 to 31/03/2019) <sup>(QOF)</sup>	93.0%	93.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	15.7% (8)	10.7%	10.1%	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 (01/04/2018 to 31/03/2019) <sup>(QOF)</sup>	84.6%	84.0%	83.6%	No statistical variation
Exception rate (number of exceptions).	8.6% (11)	6.5%	6.7%	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)	542.2	No Data	539.2
Overall QOF score (as a percentage of maximum)	97%	No Data	96.4%
Overall QOF exception reporting (all domains)	5.4%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a 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

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

Area	Improvement
Audit of antibiotic prescribing over a one month period.	Antibiotics were generally prescribed for the appropriate condition and where improvements could be made, these had been identified and shared with prescribers. Patient education resources were available and shared in the practice.
Support and review of patients with heart failure.	Initial audit to identify patients who had been coded as having heart failure. Monthly clinics established with two clinical staff to identify if diagnosis was correct and undertake intervention if appropriate. A re-audit in November 2019 was planned.

### 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.	Y <sup>1</sup>
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.	Partial <sup>2</sup>
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.	Y
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 <sup>3</sup>
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><sup>1</sup> The practice had a training matrix which included mandatory and role specific training for clinical staff which included long term locums and non-clinical staff. Training which was due to expire was identified and acted on. The oversight of staff training was undertaken by the assistant practice manager and was overseen by the GP partners quarterly, during the partners meetings. All staff had completed training for safeguarding, infection control, fire safety and basic life support and anaphylaxis at the appropriate level for their role.</p> <p><sup>2</sup> We reviewed the files of two healthcare assistants employed since 2015. Records of competency from a previous employer were in place for one health care assistant. Competency checks had been completed, for example, for immunisation training.</p> <p><sup>3</sup> Arrangements were in place for the support, development and oversight of staff working in extended clinical roles. Where staff wanted to extend their roles, this was only undertaken when a GP had capacity to mentor staff appropriately.</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 (01/04/2018 to 31/03/2019) (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

### 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 <sup>1</sup>
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
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup> The Citizens Advice Bureau was based at the practice once a week. Appointments were available through reception or by GP referral. Social services had been available at the practice once a week, but this had temporarily stopped until a replacement staff member had been identified to continue the service. Patients were referred to Onelife Suffolk for health advice and support. The practice employed a mental health nurse who worked in the practice on Monday, Tuesday and Wednesday and occasional Thursdays.</p>	

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 (01/04/2018 to 31/03/2019) (QOF)	95.9%	95.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (9)	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	Y

consent and decision making. We saw that consent was documented.	
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.	Y

## 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.	20
Number of comments cards received which were mixed about the service.	Five
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient interviews.	Staff were friendly and caring and were treated with dignity and respect.
Feedback from CQC comments cards.	Staff were caring, helpful and patient and listened to patients.
Feedback from care home representatives.	Patients were treated with kindness and respect by practice clinicians who visited. Privacy was maintained during consultations. Positive feedback was received in relation to the clinical care and treatment received.

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
9190.0	337.0	128.0	38.0%	1.39%

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	84.8%	89.9%	88.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
31/03/2019)				
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)	82.0%	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)	95.0%	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)	83.8%	86.3%	82.9%	No statistical variation

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

Any additional evidence
The practice requested feedback on an ongoing basis through a link on the practice's online access portal and paper copies available at the practice. This source of feedback started in January 2019. Responses were collated on 8 November 2019. The practice had received 56 responses. 95% of patients responded that reception staff were helpful and listened; 93% of patients responded that reception staff were polite and had a good telephone manner; 88% of patients rated the online service as good or above.

### 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

Source	Feedback
Patient interviews.	Patients were involved in their care and treatment and were listened to by clinicians.
Feedback from CQC comment cards.	Patients were happy with their care and treatment and their needs were listened to.

Feedback from care home representatives.	Care home representatives reported that the clinicians involved patients with their care and treatment decisions. Family members were involved in care and treatment decisions, where appropriate.
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### 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)	87.7%	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.	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

Carers	Narrative
Percentage and number of carers identified.	The practice had 118 patients coded as being carers. This was approximately 1% of the practice population.
How the practice supported carers (including young carers).	Leaflets were available in the practice which informed patients of sources of information and support for carers. Suffolk Family Carers attended the practice once a month.
How the practice supported recently bereaved patients.	Bereaved patients were sent a condolence card. Leaflets were available which signposted patients to sources of information and further support. Some reception staff were not clear about which services to signpost bereaved patients to. We raised this with the practice manager who agreed to advise reception staff of this information.

### 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

## 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 <sup>1,2</sup>
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><sup>1</sup> Patient demand was audited between April and September 2019 to ensure that appropriate staff were allocated to times of high demand. The practice had recently begun a three month trial, following a staff suggestion, of clinicians staffing the telephone lines between 8am and 9am. The practice also planned to add another telephone line to improve access by telephone.</p> <p><sup>2</sup> The practice employed a mental health nurse, emergency care practitioner and pharmacist, who ran an integrated clinic once a week. They met together with patients with complex needs for approximately one hour per patient, to plan and review their care and treatment. This work included the review of patients prescribed multiple medicines, which included opioid medicines, with a view to reducing these, whilst ensuring other appropriate support was in place. This was agreed in partnership with the patient. This work was overseen by a GP and this high intensity work was in place for approximately 15 patients at a time. This initiative had been running since November 2018 and the practice planned to review the initiative imminently to evaluate the impact on patient outcomes.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Saturday	8.30am to 12.30pm
Appointments available:	
Monday	8.30am to 12noon and 2.30pm to 6pm
Tuesday	8.30am to 12noon and 2.30pm to 6pm
Wednesday	8.30am to 12noon and 2.30pm to 6pm
Thursday	8.30am to 12noon and 2.30pm to 6pm
Friday	8.30am to 12noon and 2.30pm to 6pm
Saturday	8.30am to 12.30pm for pre-bookable

	appointments only.
Patients could book evening and weekend appointments with a GP through Suffolk GP+. (Suffolk GP+ is for patients who urgently need a GP appointment, or who 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
9190.0	337.0	128.0	38.0%	1.39%

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)	93.3%	95.1%	94.5%	No statistical variation

### Older people

### Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>All patients had a named GP who supported them in whatever setting they lived.</li> <li>The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs.</li> <li>The practice provided effective care coordination to enable older patients to access appropriate services.</li> <li>The practice offered home visits for older people who were housebound.</li> <li>Older patients who lived in care homes received flu vaccinations during home visits.</li> </ul>

### People with long-term conditions

### Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>Patients with a long-term condition were offered an annual review to check their health and medicines needs were being appropriately met. Patients were recalled during their month of birth.</li> <li>Patients with multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.</li> <li>One of the GPs had enrolled on a specialist diabetes course, to gain expertise in supporting patients with diabetes.</li> <li>Rescue packs were provided to patients with COPD.</li> <li>A diabetes specialist nurse held a clinic at the practice one day a week to support patients with diabetes who had more complex needs.</li> <li>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.</li> <li>Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.</li> <li>The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.</li> </ul>



## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- We found 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 a nearby location once a week.

## **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. Appointments were reviewed in April 2019 and changes were made so 25% of appointments could be booked online.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Telephone consultations were available.
- Patients could book evening and weekend appointments with a GP through Suffolk GP+. (Suffolk GP+ is for patients who urgently need a GP appointment, or who are not able to attend their usual GP practice on a weekday.)

## **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.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- Patients with sensory impairment were flagged on the clinical system to ensure appropriate care was offered at every intervention by all staff members.
- Same day appointments and longer appointments were offered when required.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## **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 in the process of becoming a dementia friendly practice.

- Staff were trained in the mental capacity act.
- The practice employed a mental health practitioner who worked three days a week. Appointment times were adjusted according to the needs of the patient.
- Patients were offered longer appointment times, if necessary.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. Information was also available on the practice's website.
- 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.
- Staff were aware of how to access the crisis team for patients with acute mental health needs.

### 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 (01/01/2019 to 31/03/2019)	67.2%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	63.2%	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)	66.2%	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)	68.7%	80.0%	73.6%	No statistical variation

Source	Feedback
Patient interviews.	Patients were able to get an appointment and commented positively on the availability of online appointments.
Feedback from CQC comments cards.	Most patients were satisfied with the appointment system. Five of the 24 comments cards we received related to some difficulty in getting an appointment.
Feedback from care home representatives.	Weekly home visits were undertaken by the emergency care practitioner to four care homes where patients were registered with the practice. Patients who were prescribed medicines were reviewed by the pharmacist and GP, as appropriate. Care home staff knew how to contact them if they had any concerns. Requests for urgent visits were usually responded to by telephone consultation by a GP.
Comments on Healthwatch Suffolk website.	Six comments had been received since March 2018. Four were positive, with patients being able to get an appointment, one was mixed, due to length of wait for appointment once arrived at the practice. One less positive comment related to difficulty in getting an appointment, but advised the practice offered a call back. The practice had a three and a half out of five-star rating based on 30 reviews.

### 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.	Ten
Number of complaints we examined.	Four
Number of complaints we examined that were satisfactorily handled in a timely way.	Four
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
Explanation of any answers and additional evidence: Suggestions and complaints information was available on the practice's website and in the practice.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Dissatisfaction with dress code.	Dress code reviewed and updated and shared with all staff.
Error with booking of appointment.	Reminder for staff to double check an appointment has been booked.

## Well-led

## Rating: Good

### 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 <sup>1</sup>
Explanation of any answers and additional evidence: <sup>1</sup> The practice had redesigned the management and clinical structure of the practice. They had employed a mental health practitioner, emergency care practitioner and a pharmacist in response to the needs of the patient population. They had employed a deputy practice manager to support the management work of the partners and practice manager. This enabled the practice manager to focus on strategic leadership, which included the future development of the practice.	

### 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 <sup>1</sup>
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 <sup>2</sup>
Explanation of any answers and additional evidence: <sup>1</sup> The aim of the practice was 'Improving primary care through vision, commitment and integrated working.' This had been updated to reflect the partnership the practice had with their primary care network. The practice values were 'We care about our community and staff. We work together. We strive for continuous growth and improvement on a personal and practice level. We focus on prevention, self-care and co-ordinated care.' <sup>2</sup> The practice had a development strategy document 2018 to 2021, which outlined aspects of development in relation to systems, workforce, patients, premises, communication and equipment. The practice recognised the building needed some modernisation and repair and that space was limited and had identified the need for new premises. Discussions about this with the local Clinical Commissioning Group were ongoing. An interim arrangement for additional space had been agreed and the practice were awaiting a structural survey.	

## 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 <sup>1</sup>
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.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <sup>1</sup> All staff we spoke with felt able to raise concerns openly with GPs and managers. Informal lunchtime meetings were held every day, which any staff member could attend to raise any issue they had.	

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

Source	Feedback
Staff interviews.	All staff we spoke with enjoyed working at the practice and worked well with their peers and other staff. They felt supported by the management team and the GPs, who they described as approachable and supportive.

## 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.	Partial <sup>1</sup>
Staff were clear about their roles and responsibilities.	Y <sup>2</sup>
There were appropriate governance arrangements with third parties.	Y <sup>3</sup>
Explanation of any answers and additional evidence: <sup>1</sup> Practice specific policies were in place and staff were aware of how to access these. Policies were available on the practice's computer and stored in hard copy in the office. The practice was uploading their policies onto the e-learning website, so staff could access these when undertaking relevant training. Policies were reviewed, however the approval of these was not always documented on the policy and there was no audit trail of change made. <sup>2</sup> The practice had a named clinical lead and deputy and an administration lead for each disease area. <sup>3</sup> The practice was part of a primary care network. They planned to recruit a social prescriber on behalf of the primary care network, to work one day a week at the practice to support patient self-management.	

## Managing risks, issues and performance

### There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial <sup>1</sup>
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.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y <sup>2</sup>
Explanation of any answers and additional evidence: <sup>1</sup> Arrangements were in place for monitoring a range of areas including the quality and outcomes framework, health and safety, significant events, complaints and training. Some risks were identified during the inspection, which had not been identified by the practice. These included out of date patient group directions, no protocol to check that all patients referred for suspected cancer had been seen by the hospital and COSHH data sheets not being available for hazardous substances used by employed staff. The practice had a risk register, which was managed by the practice manager. This was discussed with the partners as appropriate. <sup>2</sup> The workload of clinical staff had been audited to understand the impact of the recruitment of the mental health practitioner and pharmacist.	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y <sup>1</sup>
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y <sup>2</sup>
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <sup>1</sup> Improvements had been made to the quality and outcomes achievement and exception reporting, hypnotic prescribing and antibacterial prescribing, including co-amoxiclav, cephalosporins and quinolones. <sup>2</sup> The practice had analysed data and identified areas to focus on in the following 12 months. This included high intensity users and increased capacity at the premises for additional staff, as the patient population continued to increase.	

## 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 <sup>1</sup>
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y <sup>2</sup>
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: <sup>1</sup> The practice had a monthly patient newsletter, to keep patients informed of new initiatives, promote good health and to encourage feedback. <sup>2</sup> The practice had a monthly staff newsletter, to keep staff informed of new initiatives and to encourage feedback. The practice listened to and acted on staff suggestions. They were currently undertaking a three month trial, following a staff suggestion, of clinical staff manning the telephone lines between 8am and 9am.	

Feedback from Patient Participation Group.

Feedback
The practice had a Patient Participation Group (PPG) which had been established for approximately one year. The PPG met every three months to discuss recruitment to the PPG and practice updates. PPG meetings were chaired by the deputy practice manager and attended by the practice manager. Feedback about the practice and the relationship they had with the practice was positive. The PPG advised that the practice listened to their views and feedback. The PPG had identified the lack of capacity in the current building and were supportive of the current short and long term plans of the practice.

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Y <sup>1</sup>
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <sup>1</sup> The practice had supported the pharmacist to undertake their non-medical prescribing course. The salaried GP had enrolled on a specialist diabetes training course.	

Examples of continuous learning and improvement
<p>The practice was seeking to provide additional social prescribing support for patients through the Orwell primary care network. They had recently advertised for the post of social prescriber and were looking forward to recruiting to this.</p> <p>The practice was part of the Chantry Partnership Group, which included representatives from the police, schools, council, voluntary organisations and health and social care organisations. They met every six to eight weeks with the aim of raising the aspirations of children living in the locality. The group had held a family fun and well-being event in July 2019.</p>





## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## 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.